State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 13, Day 2007 Year Physician 7:56 Рм Frank Mazeika /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring
If Under 1 Year | If Under 24 Hrs 14105 Sturtevant Road Montgomery Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Hours 1 € M 2 □ F Director 89 15, 1917 Lithuania 068-26-4565 Aug. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f sh notified 1 ☐ Yes 2 → No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 20905 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must 14105 Sturtevant Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Physician Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Mazeika Honorata Draufkaitif 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Downs/ Daughter 14105 Sturtevant Road, Silver Spring, MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State April 18 1X Burial 2 ☐ Cremation 3 X Removal from State St. Casimir's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Chicago, Illinois 21. Signature of Funeral Service icensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Inanition /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Congestive Heart Failure
Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical Senile Dementia attending ph for use as th IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 1 🔽 Natural (Month, Day Year) Injury 5 ☐ Pending 1 □ Yes 2 □ No s after death.

I Director: A
d in by the fu investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide txxcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier d25345 April 16, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Glancy, M.D. 1731 Briggs Chaney Road, Silver Spring, MD 20905 ₩gistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2007

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21215-0036	within 72 hours after death with the Maryland ene. then "naturet, or iteme 23e or 28e-f ehow he Medical Exeminer must be notified at	Completed	,	15. Decedent's Specify only highest of			16a. Dece	dent's Us	ual Occup	ation during mos	t of workin	10	16b. K	and of Busin	ess/Ind	dustry	
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-	, -		30. Name and	address of person wh	no completed cause	of death (Ite		, Print)									
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DHMH 17 Rev 1/2001

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#234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Lorenzo Dow Mason 4 07 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death CENTER DALISBURY NICOMICO REGIONAL eDICAL. Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 6. Sex Days Hours 1 X M 2 □ F 207-12-2483 81 Nov. 6,1925 MD Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No MD Worcester Snow Hill 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 309 South Bay St. 21863 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: WW I I 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify. Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4cr 5+) Supervisor Grocery Chain 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lorenzo D. Mason Hattie Guv 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4485 Scotty Rd., Pocomoke City, Md. 21851 Gerald T. Mason (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Christian Ch. Cem. 04-21-2007 | Snow Hill, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature Funeral Service Line 108 William St., Berlin, Md. 21811 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) Respiratory weeks Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 219 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1. Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner the death certificate be executed Division or Vital Records, P.O. Box 68760, physician the as attending p page 2 s has To the Hospital or Attending Physician:

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Physician

/Medical

Examiner

Director

Completed by Funeral

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Physician/Medical

Completed by

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Certification: To

Medical

29a, Certifier

29b. Signature and title of certifier

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

س within منت wental Hygiene. عr 27 is marked other than "r r traumatic event تت

Physician

/Medical

Baltimore, Maryland 21215-0036

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State Registrar

DR- USHA NATESAN. 31. Date filed (Month, Day, Year)

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and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Registrar's Signature

DHMH 17 Rev 1/2001

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ST

29c. License number

D057359

SALISBURY

29d. Date signed (Month, Day, Year)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

-		For State Registrar		C	ertificate of	Death	F	Reg. No.			
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or Items	Funerai	11. Marital Status	12. Was Decedent B Armed Forces?		 Was Decedent of I If Yes, specify Cub 	an, Mexican, Puert	o Rican, etc.)	Black, White			
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DHMH 17 Rev 1/2001

VA

Registrar

State

Baltimore, Maryland 21215-0036

Box 68760,

P.O. I

Division of Vital Records,

600 Memorial Ave., Cumberland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Registrar's Signature

Harjit Sidhu, MD

APR 23

31. Date filed (Month, Day, Year)

D1690

21502

200

	1- For State	State of Maryland	/ Department o		d Mental I		2	007	14001
Physician/	1. Decedent's Name (Fir		00111110010	-		2. Date of Death			me of Death
Medical Examiner		James McQuaid				Month April 22, 20	Day Yea)07	19	901 hrs
	4a. Facility Name (if not 3925 Folly Quar	t institution, give street and number arter Road	r)	4b. City, Town, or Ellicott City		ath	4c. County of Howard	f Death	
Funeral	5. Social Security Number		ge (In yrs. last birthday)	If Under 1 Yea		din.	MM/DD/YYYY	9. Birthplac Foreign	e (State or
irectorک	215 06 2980		34 Yr		s Hours IV	03/15/	1973	Country)	MD
, fu	Usual Residence of Dec 10a. State 10b.	cedent . County	10c. City, Town or Loca	tion				10d.	Inside City Limits
show z	MD	Howard	Ellicott	Citv				1	Yes 2 X No
AE Surfand n or 28a-f show iffed at once. Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	at Country?	
th the Maryland 23a or 28a-f she notified at once	9424 Til	ler Dr.		2104	2		USA		
and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she transmatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 1 X Never Married	2 Married 12. Was Deceder Armed Forces		as Decedent of Hi		Specify Yes or No- rto Rican, etc.)	14. Race White	- American Ir	idian, Black,
er dea	3 Widowed 4	Z IWATTICU	X No	Yes 2 X No			Specify:	White	
urs aft		or Dates:	mpleted) 16a. Decede	nt's Usual Occupa	tion (Give kind o		16b. Kind of Bu		
5-0036 ed within 72 hour bygiene. Other than "natu the Medical Exan	Elementary/Secondar		5+) during r	nost of working life	. DO NOT use r	retired)			
5-0036 led within 7 Hygiene. other than the Medical		5+	Gradu	ate Stude		ial Work	Educa		
215-1 be filed ntal Hyg rked oth ent, the	17. Father's Name (First Philip Jame)					me (First, Middle, N)	
212 ould be ould be d Ments s mark ite ever		Relationship (Type, Print)	19b. Mailır	g Address (Stre		or Rural Route Num		n, State, Zip (Code)
MD 12 shc th and 127 is		McQuaid/Father	9424	Tiller H	Orive El	llicott C	ity, MD	21042	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. To Be Completed by F	20a. Method of Dispositi	tion Cremation 3 Removal from S	20b. Place of Dispo crematory or o		metery,	Date	20c. Location -	City or Town	, State
imc Page ment tant: or otl	4 Donation 5	Other Specify:	St. Johns		-	-28-2007			
Baltil Permit. Departm Importa injury o	21 Signature of Funeral	Service Licensee	M01044 22.	Name and Addres	s of Facility Ha	arry H. W	itzke's	Famil	y FH Inc.
Physician	23a. Part I. Enter the dis	sease, or complications that cause				a Pike El			MD 21043 proximate Interval
/Medical	failure. List only on	ne cause on each line.	e and alcohol :						tween Onset and Death
Examiner	Immediate Cause (Final or condition resulting in			IIIOXICILIC	л1				
5	Sequentially list condition if any, leading to immediate		aguana of						 ;
aii aii	cause. Enter Underlying (Disease or injury that in	g Cause	sequence on.						
ecuted and rransit	events resulting in death	th) Last Due to (or as a cons	sequence of):						
Box 68760, e death certificate be executed the attending physician and ed for use as the burial – transi hysician/Medical E.	X UNPENDED	d	20 6 15						
60, ate be exc obysician ne burial -	IF FEMALE:	23C. II yes, outco	28a-f.perME, ga	367 , 5/7/07	TT		23d. Date of	delivery	
30x 6876C death certificate te attending phys I for use as the b	23b. Was decedent pregi past 12 months?	nant in the	2 F	etal death 3	Ectopic pres	gnancy	Month	Day	Year
). Box 6876 the death certificate opy the attending phy ched for use as the Physician/M	1 Yes 2 No 9		at time of death 5 C	ther (Specify)					
tal Records, P.O. B cinn: The law requires that the d certificate has been signed by the ector, page 2 should be detached.	Part II. Other significan	nt conditions contributing to dea	th but not resulting in the	underlying cause	given in Part I.	23e. Did to	bacco use contr	bute to the ca	ause of death?
s, P.O. ires that the signed by the detacletacletacletacletacletacletacletacl						1 Yes	2 No 3	Probably	4 V Unknown
Records, The law require ficate has been signage 2 should be						24a. Was a autop	sy r		findings available etion of cause of
Recorder to the lage and page 2						perfor		leath? Yes	2 No
Division of Vital Records, tal or Attending Physician: The law require as after death. Pull Director: After this certificate has been si the interior, page 2 should be in by the funeral director, page 2 should artification: To Be Completed	25. Was case referred to examiner?	Hospital:			e of Death (Che				
of Vi ing Physi After this uneral dir	1 Yes 2 27. Manner of Death	No 28a. Date of In	ient 2 ER/Outpatier		Other Nur		Residence 6 own		ne
ion of Veath cath. tending Physical Court After to the funeral ation: To	1 Natural 5	Pending (Month, Day,	Yeer)		Yes 2 X No		low injury occurr	ea	
ivision or Attent after death Director; In by the	2 Accident 3 Suicide 6	Investigation Find 4/25	/2007 Find 6:5 Injury - At home, farm, stre	O DILL		unknown 28f. Location (S	treet and Numb	er or Rural Ro	oute Number, City
Division o Hospital or Attending 24 hours after death. Funeral Director: After tedy filled in by the fune al Certification:	4 Homicide		ther-scene			or Town, S Ellicot	tate) 3925 T	Olly Qu	arter Rd.
Division of Vital Records, P.O. Box 68760 within 24 hours after death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/Medical Certification:		tifying Physician: To the best of r	my knowledge, death occu			and due to the caus	e(s) and manner		se(s)
Σ	29b. Signature and title	of certifier	·	29c. Licens	se number		29d. Date sign	ed (Month, D	ay, Year)
3 Jm	Caled	of person who completed cause of	death (Item 23c)	O.C.	M.E.		April 23, 20	007	
	Zabiullah Ali, M	1.D. Assistant Medical E	xaminer 111 Pe	nn Street, Bal	timore, MD	21201			, <u> </u>
State Registrar	31. Date filed (Month, Da		ar's Signature						
DHMH 17 Rev 1/2001		N 0 2001	ORIGINA	Market)					

77-02044	Please Type of Print in Black Indelible Ink. Ensure Al	I Copies Are Legible.			
Brian Andrew McAlwee	State of Maryland / Department of Health and M	ental Hygiene	2007	111.0	No.
1- For State	Certificate of Death		6001	1 1 0	100
Registrar	Certificate of Death	Reg. No.	_		
Physician/ 1. Decedent's	s Name (First, Middle, Last)	2. Date of Death	3.	Time of Death	_

		1- For State Registrar		C	Certifica	ate of	Death			F	Reg. No.	()	10. 1	1 10	U
Physici	1111	Decedent's Name (First, Middle				_				ate of De	ath Day	Yea		3. Time of Death	
Medical Exami	ner	Brian And							A;	pril 14,	2007			0125 hrs	
)		4a, Facility Name (if not institution 16808 Aquasco Rd.	n, give street and	number)		41	b. City, Town, o Aquasco	r Location of [Death		1	County o		s	
Funeral		5. Social Security Number	6. Sex	7. Age (In y	rs. last birt	hday)	If Under 1 Ye	ar If Under 2	24Hrs. 8.	Date of B	irth(MM/I	DD/YYYY		place (State or	
Director		219-17-9154	1 X M 2	F 21		Yrs.	Months Day	ys Hours	Min.	ay 31	1. 19	985	Foreign Cou	h _{ntry} Marylar	nd
	į	Usual Residence of Decedent								<u></u>	-,	,,,,	L		
r any		10a. State 10b. County		10c. 0	City, Town	or Locatio	n							10d Inside City Li	
and show	5	Maryland Prince	e Geroge	's A	quas	00								1 Yes 2 X	No
re Maryland or 28a-f show fied at once.	Director	10e. Street and Number					10f. Zip Code				10g. Citiz	en of Wh	at Coun	ry?	
t with the Maryland ms 23a or 28a-f sho be notified at once		23000 Neck Ro	ad				20608	}				US			
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shi natic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status		Decedent Ever in d Forces?	n U.S.		Decedent of Hi				0-	14. Race White		an Indian, Black,	
r deat	띪	1 Never Married 2 Ma	1 Ye	s 2 X N	0				4011011104	ar, 0.0.		rinic			
s afte			orced If Yes, Give or Dates:		10		Yes 2 No				-	Specify .		ite	_
hour hatu	ğ	 Decedent's Education (Specific Elementary/Secondary (0-12) 		e (1-4 or 5+)			s Usual Occupa st of working life			aone	166. K	ind of Bus	siness/Ir	dustry	
5-0036 iled within 72 hours after Hygiene. 1 other than "natural", the Medical Examiner	Completed by	12	Colleg	8 (1-4 Or 5+)		М	echanio					г1.			
d with	E O	17. Father's Name (First, Middle,	Last)		L		echanic	18.Mother's I	Name (Firs	st. Middle.	Maiden :		vato	or	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than event, the Medica		, , ,	,	r				Andre	•			,			
2121: vuld be fil Mental I marked	2	Thomas Bond McA 19a. Informant's Name/Relations	hip (Type, Print)	· · ·	198	o. Mailing	Address (Stre				ımber, Cit	ty or Town	n, State,	Zip Code)	
imore, MD 2 Pages 1 and 2 shou ment of Health and N lant: If item 27 is n or other traumatic		Thomas B. McAlv	wee, Sr.	- Fath	er 2	2300	Neck Ro	ad. Ao	าแลรดด	o. MF	206	เกล			
ore, MC es 1 and 2 s of Health an If item 27 her traums		20a. Method of Disposition		20	0b. Place o	of Disposit	ion (Name of ce	emetery,	Da	te	20c. L	ocation -	City or	own, State	
MOF Pages ent of nt: If		1 XBurial 2 Cremation 4 Donation 5 Other Sp		I from State		•	Epis.	Cem O	14_17_	-2007		111200	ο N	חו	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr	Ť	21. Signature of Funeral Service	Licensee	M01246	0. 110	22. Na	ame and Addres	s of Facility	7-17-	3035	014	Wash	inat	on Road	
0 5 2 1 1		Jack A. Wi	LSON			Hun	tt Fune	ral Ho	ome V	va I do	orf,	MD 2	0601		1
Physician		23a. Part I. Enter the disease, or failure. List only one cause		at caused the de	ath. Do no	t enter the	e mode of dying	, such as card	diac or res	piratory ai	rest, sho	ck, or hea	ırt	Approximate Inte Between Onset	
/Medical Examiner	- 1	Immediate Cause (Final disease	_	<u> </u>										Death	
		or condition resulting in death)	Due to (or a	as a consequent	ce of):										
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a consequenc	ce of):										
	Ë	cause. Enter Underlying Cause	С.		,										
ed	Examiner	events resulting in death) Last	,	as a consequen	ce of):										
760, cate be executed physician and the burial - transi	g	UNPENDED	dAMENDE											-	
50, te be	n/Medical	IF FEMALE:		es, outcome of p	veccosov						230	. Date of	delivery		_
8760 Tificate bing physical	5	23b. Was decedent pregnant in the past 12 months?		e birth		Feta	al death 3	Ectopic p	pregnancy		250	Month		ay Ye ar	
Box 687 te death certific the attending p	Sici		4 Pr	egnant at time o			er (Specify)				0				
BC BC he dea	Physicia		9 Or	iknown						00- Did					
;, P.O. ires that the signed by	by F	Part II. Other significant condition	ions contribution	ig to death but n	iot resultin	g in the ur	nderlying cause	given in Part	: I.	_	_	_	_	he cause of death' ably 4 Unkno	
S, F luires on sign	pe								— ļ	24a Wa				opsy findings avail	
ord aw rec as bec	per l								_	auto	psy	р		ompletion of cause	
Rec The 1s cate h	Completed										formed?		✓ Ye	2 No)
tal Rec ian: The certificate ector, page	Be	25. Was case referred to medica examiner?					26.Plac	e of Death (C	Check only	one)					
Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been seled in by the funeral director, page 2 should it	P	1 Yes 2 No	Hospital: 1	Inpatient 2		utpatient			Nursing Ho			nce 6 🗸		Scene	
n of \ding Ph;		27. Manner of Death 1 Natural 5 Page	Λ n. (M	ate of Injury onth, Day Year) 4, 2007		Time of In 7 hrs	· · _ ·	ury at Work? Yes 2.✔ N	Driv	l. Describe ver of v				trol and hit fix	ed
iSior Attend or death rector: by the	ati	= J Penc	stigation						ODJe		.0			IB I N what	Otto
Division Sepital or Attenchours after death	Certification:		a not be	Place of Injury -	At home, to	arm, stree	t, factory, office	building, etc.		or Town.	State)			al Route Number,	City
ospita hours nuera y fille		4 Homicide	, (opac	Street						08 Aqua				٠	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	ical	(Check only Certifying Pi	hysician: To the miner:On the ba		_										
To the within To the Comple	Medical	29b. Signature and title of certifie	and mann					ise number						th, Day, Year)	
		Will - A		Dan	0			.M.E.				14, 20			
		30 Name and address of a	- Landa commission	TOLL	er con	<u>~</u>									
SRI		30. Name and address of person Patricia Aronica-Pollal		sause of death (istant Medic		niner	111 Penn S	Street, Balt	timore. N	MD 212	01				
DUG	tate			. Redistrar's Sig											
Regis		31. Date filed (Month, Day, Year) APR 1	7 2007	Home	K	do	est 1								

Ω	D B	<u>E</u>
	Phy /M Exa	
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
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		Pleas	se Type or Pr						9	ible.			
		For State Registrar	State of I	Marylan	-	artment of H rtificate of I		Mental Hy					
r.		Registrar 1. Decedent's Name (First, Middle	. Last)		Cel	illicate of i	Dealli ———————————————————————————————————	2. Date of D	Reg. No.	107	3. Time of Death	3	
Physici: /Medic		Samuel Lewis Pl	acanica					Month April	Day	Year 7	9:56 PM		
Examin		4a. Facility Name (If not institution		er)		4b. City, Town, or	Location of Death		4c. Count				
		1611 Cody Drive					r Spring			ntgor			
Funeral Director		5. Social Security Number 234-42-9624	6. Sex 7. 11x M 2 F	3 , ,	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ay, Year)	Cou	place (State or Foreign intry)		
		Usual Residence of Decedent		77				June 17	7, 1929	West	. Virginia	_	
arylan show	L	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits		
he Ma '8a-f s	Director		gomery		Silv	er Spring	1				1 ☐ Yes 2 ☑ No		
with t	Ö	10e. Street and Number				10f. Zip Code			10g. Citizen of		intry?		
death ms 23 musi	Funeral	1611 Cody Dri	12. Was Decede	nt Ever in U.	.S. 13.	20902 Was Decedent of H		pecify Yes or N	USA 0- 14. Ra		can Indian.	_	
after or Iter	Fur	1 ☐ Never Married 2√ Marri	Armed Force ed 1 Yes 2 [If Yes, Give	7 No		Was Decedent of H		Rican, etc.)		ck, White	, etc.		
ours ural";	d by	3 Widowed 4 Divorced	Year or Date	s:	Korea	1 ☐ Yes 2 ☑ No	Specify:		Specia	fy: Wh	nite		
n 72 h "nati	Completed	15. Decedent (Specify only highes	s Education t grade completed)		16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of world	king	16b. Kind of B	lusiness/Ir	ndustry		
l withii liene. r than the M	шо	Elementary/Secondary (0-12) 12	College (1-4d	or 5+)		ems Analys			Mationa	1 50/	curity Agen		
e filed al Hyg other	Be	17. Father's Name (First, Middle, I	Last)		Dysce	and Andrys	18. Mother's Nam	e (First, Middle			curicy Agen	IC	
Menta Menta arked atic e	일	Ilario Placani	ca				Mar	ia Lava	arato				
l 2 sho		19a. Informant's Name/Relationsh			1 -	ng Address (Street					p Code)		
1 and Health em 27		Mary R. Placan 20a. Method of Disposition	ica/ wire	20h F		Cody Driv	re, Silve	r Sprin			Charles	_	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and Sehould be filed within 72 hours after death with the Maryland Important; If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1√ Burial 2 Cremation	3 ☐ Removal from Sta	te C	emetery, cre	matory or other plac	, <u>r</u> = -		20c. Location				
mit. Partme		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service I		Ga	22	Heaven Ce 2. Name and Addres	ss of Facility	2007			ng,Maryland	<u> </u>	
permi Depa Impo any Ir		> True &	Scento			Francis 3	J. Collin ersity Bl	s Funer	al Home	Inc	ng, MD 2090	11	
		23a. Part. Enter the disease, of shock, or heart failure. List	complications that cause on each	ed the deatl	h. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	arrest,		Approximate Interval Between	_	
Physician		Immediate Cause (Final disease or condition	_a Metast	atic	Pancre	atic Cand	cer			2	Onset and Death Months		
/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):							_	
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e exec		resulting in death) Last		as a consequ	uence of):		·					\neg	
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical		d					<u> </u>					
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atten for us	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 ☐ Feta	Ideath 3	⊒Ectopic pregnancy ⊒Other (specify)	,			ate of deliv	ery Day Year		
t the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknowr										
ss that	by P	Part II. Other significant condition	ns contributing to death	but not resi	ulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use con	tribute to	the cause of death?		
w require been sig should b	led			_				1 🗆	Yes 2 X No	3 ☐ Pro	bably 4 ☐Unknown		
has be	Completed							24a. Was	an 24b.	Were aut	opsy findings available ompletion of cause of		
r: The								perf 1∐ Yes	ormed? 2 No	death? 1 ∐ Yes			
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g Phy er this	. To	1 Yes 2√2 No 27. Manner of Death	28a. Date of I	njury	ER/Outpatien 28b. Time of	IL SU DOA	4 LI Nursing Ho		how injury occur		fy)	\dashv	
ath. rr: Afte	Certification:	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investig		Day Year)	Injury		k? Yes 2∐No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
r Atte er de: Irecto	tific	3 Suicide 6 Could n 4 Homicide determi	and Zoe. Place of	njury - At ho	ome, farm, str	eet, factory, office		28f. Location ((Street and Num wn, State)	ber or Rui	al Route Number,	┪	
oital ours afteral Dilled in													
To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical 8	Physician: To the be Examiner: On the basis and manner	of examina	wledge, deatl tion and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time	cause(s) and m , date and place,	anner as	stated. to the cause(s)		
ro the vithin ro the comple	Mec	29b. Signature and title of certifier	andmanner	Stateu.		29c. License	e number		29d. Date signe	ed (Month,	Day, Year)	-	
17+1		· Ch	عملا	w)		D33224				2007		
(0,1	-	30. Name and address of person v	vho completed cause o	f death (Item	23a) (Type,	Print)						-	
		Ram S. Trehan, I				n Road, S	Silver Sp	ring, M	ID 20910				
Sta Registra		31. Date filed (Month, Day, Year) APR 1 7 2		strar's Signa		es a							
HMH 17 Rev 1/20		WEW I (C)	AUTOLOGIA	1 15	Apan.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month AFRIL **Physician** John Joseph Paszkiwicz

Day 11, 2007 2:44A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Center Towson Baltimore 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours Yrs Director 212-30-2145 07/17/1931 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Directo 1 ☐ Yes 2 No Ellicott City MD Howard 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9032 A Town and Country Blvd. 21043 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Disabled 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Paszkiwicz Amelia Kuucinska 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other troonce. Angeline A. Julio-sister 14711 Hanover Pike Upperco, MD 21155 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cremation 104/12/2007 | Hampstead, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eline Funeral Home Moo1490 mi 934 S. Main St. Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE ON CHRONIC RENAL FAILURE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 Other (specify) ed by the a 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CORONARY ARTERY DISEASE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No has e 2 s autopsy page his certificate I 1□ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: this , 1 Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA After th funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No

Certification:

Medical

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

Within 24 hours ane
To the Funeral Director: Aft

State Registrar 22 m-0 29c. License number D41410

TOWSON,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 200

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

determined

JOGINDER MEHTA 7601 M. D. OSLER DRIVE

31. Date filed (Month, Day, Year) 32. Registrar's Signature **APR 13**

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			1 - For Stete Registrer		e of Ma	aryland	•	rtment tificate			and M		Rag. No.	6 H H I 7	14010
	Physici	an	Decedent's Name (First, Mic	ldle, Last)								2. Date of De Month	ath Day 14	Year	3. Time of Death
	/Media	cal	Consiglia				Pasto				/ D = 15	April			5:27 P M
	Examir	er	4a. Facility Name (If not instituted 116 Park Tox		,			4b. City,		Location of	of Death		4C.	Cecil	
,	Francis		5. Social Security Number	6. Sex		e (In vrs. la	st birthday)	If Under		If Under	24 Hrs.	8. Date of Bir	th		lace (State or Foreign
j	Funeral Director		178-18-7657	1 ☐ M 2 []		84	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Nov. 7	y, Year) 1 Q	22 Irni	lace (State or Foreign hry) Bagnoli no, Italy
			Usual Residence of Decedent		1							110 7 1	, 17	ZZ ZIPI	no, reary
	anylan ehow	_	10a. State 10b. Cour	,			Town or Lo	cation						1	Od. Inside City Limits
H	ith the Ma or 28a-f	cto		Cecil		ETR	ton								1 X Yes 2 No
1	death with the Maryland me 23a or 28a-f ehow Emust be notified at	Funeral Director	10e. Street and Number 116 Park Town	e Drive				10f. Zip	Code	2192	1	:	10g. Citi	U.S.A.	itry?
Sig	2 2 2	by Fune	11. Marital Status 1 □ Never Married 2 □ M 3 ፟ Widowed 4 □ Divorce	arried Arme	Decedent I ed Forces? Yes 2 1 1 es, Give r or Dates:		l l	Vas Deced i Yes, spec		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	•	14. Race - Americ Black, White, Specify:	
7	21215-0036 d within 72 hours att giene, or then "neturel; or the Modest Exerci-	ted	15. Deced	ent's Education			16a. Deced	lent's Usua	l Occupa	ation			16b. Ki	nd of Business/Inc	dustry
3	212 7 nin 7	Completed	(Specify only high Elementary/Secondary (0-12	nest grade comple	e <i>ted)</i> ege (1-4or 5	+)	(Give life. L	kind of wor OO NOT us	k done d e retired,	luring mosi)	t of worki	ng		lical Tub	_
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9	- n = 0 5	Be	17. Father's Name (First, Midd Antonio Gatt								_	(First, Middle,			
	Marke marke	2			41		105 11-11-		(0)	0rs		•		Gatta)	0-11
A	Man d 2 sl th an treur treur		19a. Informant's Name/Relation Michael A. Pa		″ (Son)									r Town, State, Zip :laware 1	
	Te, and Heal		20a. Method of Disposition		(5011)							ate		cation - City or To	
4	Baltimore, Marylar permit. Pages 1 and 2 should by Department of Health and Menta important: if them 27 is marked eny holury or other treumatic engage.	1 ☐ Burial 2 🌠 Crematio 4 ☐ Donation 5 ☐ Other	Date 20c. Location - City or Town, State 20c. Location - City or T												
S	alti mit. partm ports y inju		21. Signature of Funeral Servi		7)		22	Name and	d Addres	s of Facilit					
0	m &&E\$8		Buston	Eliki C.	Man	ئب	H:	icks i 03 W.	Sto	ckton	Fune Str	rals. E	A. Iktor	n. Marvla	and 21921
4			23a. Part . Enter the disease, show, or heart failure. L	or complications t	that caus	the death.	Do not ente	er the mode	of dying	g, such as	cardiac c	or respiratory a	rrest,		Approximate Interval Between
	Physician	П	Immediate Cause (Final disease or condition		HI	~し	rei	m.	ev	-3		150	~ 3	32	Onset and Death
	/Medical Examiner		resulting in death)	Du Du	ue to (or as	a conseque	ence of):				- 12	_			
X		<u>ة</u>	Sequentially list conditions,	b	es to fin an	5 (B) (B) (B) (B) (B)	na di								
t,	nsit	ulu	cause. Enter Underlying Cause (Disease or injury	squentially list conditions, Due to (or as a consequence of). use. Enter Underlying ause (Disease or injury											
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	760, te be ex ysicien	call		d											
	or titical	D	15.551.11.5												
	Box Bath cer attendir for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1 DL	s, outcome Live birth Pregnant at	2 Fetal c	leath 3 🗆	Ectopic pre Other (spe						23d. Date of delive Month	ery Day Year
	A.C.	hys	9 Unknown		Unknown										
	rdS, Fquires that an signed old be de	þ	Part II. Other significant cond	itions contributing	to death bu	at not result	ting in the ur	nderlying ca	use give	n in Part I.			obacco u Yes 2{		ably 4 Winknown
	UNISION OT VITAL HECOTIS, I or Attending Physician: The law requires the fitar death. Director: After this certificete has been signed in by the funeral director, page 2 should be or	Completed										24a. Was autor perfo		24b. Were auto	psy findings available impletion of cause of
	VITAL ilcian: T certificat rector, pa	0	25. Was case referred to predi	cal						26 Place	ol Death	1 ☐ Yes 1 <i>Check only</i> o		1 ☐ Yes	211No
	ysicia ysicia is ceri	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	1 🗆 Inpatie	nt 2∏E	R/Outpatien	3 □ DO	Othe	VE.		- /		6 ☐Other (Specifi	w)
	P Ph		27. Manner Death	28a. l	Date of Injur (Month, Day		8b. Time of Injury		3c. Injury Work			28d. Describe I			,,
	VISION Attending r death. ector: After	atlo	E - 1.00100111	stigation	(Month, Day	r our)	пцыу	М		/es 2 □ I	No				
·	DIVISIO	Certification;		d not be mined 28e. I	Place of Injubulg	iry - At hom :. (Specify)	ne, larm, stro	et, lactory	office		:	28I. Location (City or To	Street an vn, State	d Number or Rura)	l Route Number,
	Hospite 24 hours Funere tely filla	edical C	29a. Certifier 1 Certification (Check only one) 1 Medic	ying Physician: T al Examiner: On	To the best of the basis of manner sta	examination	ledge, death on and/or inv	occurred a restigation,	in my op	e, date an	d place, a	and due to the ed at the time,	cause(s) date and	and manner as si place, and due to	ated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certi					29c.	License	number			29d. Dat	e signéd (Month./	Day, Year)
	. >=0		Yoka				/	an	V	(A)	54	449	1	4116/1	06
			30. Name and address of person	on who completed	cause of de	eath (Item 2	23a) (Type,	rint)]	1 /	21 (1 3		-111	
	10			onson	MD	> 111	wes	His	ih.	Jt 2	Dui-	te De	7 6	Mon	MD21921
	Sta Registr		31. Date filed (Month APR)	7 2007	32. Pegistra	ar's Signatu	8 A	perte							
	, logisti				//										

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.
AMEND ITEM#7, 8, perFH, G867, 5/2/07, WS
State of Maryland, Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9,2007 **Physician** April William Ε. 8:28 pm Phipps /Medical 4a. Facility Name (If not institution, give street and number)
Caroline Home for Hospice 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Denton 8. Date of Birth (Month, Day, Ye 9/24/34 If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min 214-30-6392 Annabolis MD 1**X** M 2□ F **72** Yrs. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Me Ilcal Examiner must be notified at MD 1√2 Yes 2 No Caroline Denton Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 6320 American Corner Rd. 21629 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Ite tys 2□No fres, Give Year or Dates: Vietnam 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: \$ Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Contractor/Owner Building Construction nt of Health and Mental Hyg :: If item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edwin Phipps 2 Clara Langville 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. Scott Phipps Son 3556 Lochaven Dr. Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Cemetery injury 4 ☐ Donation 5 ☐ Other (Specify) 4/12/2007 Annapolis, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hardesty Funeral Home P.A. any 12 RidgeTy Ave. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Obstructive **Physician** Chrunic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading Limited at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the a detached f 1 Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 TY Yes 3 ☐ Probably 4 ☐ Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has page 2 autopsy performed' certificate 2 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospice 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident i Director: d in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 0 29b. Signature and title of cartifier D51819

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month

104

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mutthew I Multiplied CT 5-ite Zul Ameplis MD

Karmalaii Rupcha	1	- For State	tate of Mar	yland		rtment of tificate of		Mental		. 20	n7 Lin 2
Physician		Registrar 1. Decedent's Name (First, Mid	dle.Last)			inicate c.	Dealii		2. Date of Deat	g No. — — h	3. Time of Death
Medical Examin	-	Karmalall							Month April 10, 2	Day Year	1335 hrs
		4a. Facility Name (if not institut		d number	·)	1	b. City, Town, or l	ocation of D		4c. County of	Death
		3412 Hewitt Avenue	#201				Silver Spring	J		Montgom	ery
Funeral		5. Social Security Number	6. Sex	7. A	ge (In yrs, la	st birthday)	If Under 1 Year				9. Birthplace (State or
Director		220-53-41.86	1 X M 2	F	73	Yrs	Months Days	Hours	Min. 01/23/	1934	Foreign Country) Guyana
		Usual Residence of Decedent					J				
any.		10a. State 10b. Count	/		10c. City,	Town or Locati	on			<u>-</u>	10d. Inside City Limits
and show	5	Maryland Montg	omery				Silver Spr	ing			1 Yes 2 X No
ne Maryland or 28a-f show any fied at once.	Director	10e. Street and Number					10f. Zip Code		10	g. Citizen of Wha	t Country?
he had a street	ā∣	3412 Hewitt A	venue, #20	1			209	06		U.S	5.A.
ms 23	Funeral	11. Marital Status	12. Was		t Ever in U.S		s Decedent of Hisp	panic Origin?	(Specify Yes or No-	14. Race -	American Indian, Black,
death or ite	Š	1 Never Married 2 X	1 Ye	es 2	X No	11 1	es, specify Cuban,	Mexican, Pu	ieno Rican, etc.)	White,	etc.
after			ivorced If Yes, Give or Dates:			1	Yes 2 X No			Specify:	White
hours	8	15. Decedent's Education (Sp					t's Usual Occupations of working life.			16b. Kind of Busi	ness/industry
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Baltimore, MD 21215-0036 Demit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	m)	Mahadoodorie Agne			Ouse						yland 20906
Baltimore, MC pernit. Pages I and 2 si Department of Health an Important: If item 27	-	20a. Method of Disposition	3 Rupellallu	эр			ition (Name of cerr		Date		City or Town, State
more Pages 1 nent of 11 ant: If i	1	1 Burial 2 X Cremati		al from S	late	rematory or otl					
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Examiner		Immediate Cause (Final diseas or condition resulting in death)				١.					Deau
	-		b.	as a con	sequence of).					
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ed usit	Examiner	events resulting in death) Las		as a con	sequence of):					
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		25. Was case referred to medi	ool			 	26 Place	of Death (Ch	1 Yes	2 No 1	Yes 2 No
ital sician s cert	ŏ	examiner?	Hospital:	Innat	tient 2	ER/Outpatient		Other	tursing Home 5	Residence 6	Other: Scene
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State of Maryland / Department of Health and Mental Hygiene Stata Registra AMEND#17perFH4/17/07, BMW, McCo Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2007 April 16, **Physician** 11:00 A.M Miriam ROSENBERG /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Montgomery General Hospital 01ney 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day.

Nov. 20, 9. Birthplace (State or Foreign New York **Funeral** 1 □ M 2 🕏 🕏 099-18-7405 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itsms 23a or 28a-f show the Medical Examinar must be notified at Silver Spring 1 ☐ Yes 2√ No MD Montgomery Director 10e. Street and Number 15101 Interlachen Drive, #521 10f. Zip Code 10g. Citizen of What Country? 20906 U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pagas 1 and 2 should be filed will Department of Health and Mental Hygien important: if ten 27 is marked other than any injury or other traumatic avant. Ins. 0068. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Benjamin Kirschner Anna Kaufman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6100 Nightshade Court, Rockville, MD 20852 Louis Novick / son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Mt. Lebanon Cemetery April 18,2007 Adelphi, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Fugeral Service Licenses 254 Carroll St., NW, Washington, DC 20012 1/4 Approximate Interval Between Onset and Deal 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line, Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) tastatic **Physician** month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Clostric 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2. No 1 Tyes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1. Natural 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Sidnature and title of certifier 29c. License number lemano 30 Jame and address of person who completed cause of death (yem 23a) (Type Print) Drive Olney, 3 Registrar's Signature 31. Date filed (Month, Day, Year) State 7 2007 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	aryiano			t of Hea e of Dea			Jiene leg. No.	0.00				
¥	Physici	an	1. Decedent's Name (First, Middle, La	ast)						2. Date of Dea Month	th Day	Year	3. Time of Death			
12	/Medic	al .	JAMES FRA 4a. Facility Name (If not institution, give		NZ		4h City	Town or Loc	ation of Death	APRIL		2007	1:05 A M			
7	Examir	er	6001 Muncaster Mi		sey H	House	4b. Oity,	Rockvi			!	ntgome	ry			
	Funeral		Social Security Number 6. 5		e (In yrs. la	st birthday)	If Under Months		Under 24 Hrs. Durs Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	lace (State or Foreign try)			
L,	Director		156-48-3521 Usual Residence of Decedent	IM ZUF	44	Yrs.				Dec. 2	7 1962		Jersey			
	/land ow		10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits			
	a-f sh	ctor	Md. Mont	gomery				Olney					1 ☐ Yes 2 🕱 No			
	or 28	Director	10e. Street and Number				10f. Zip	Code		1	l0g. Citizen o	of What Coun	try?			
	s 23a nust I	eral	3609 Dellabrook	Street 12. Was Decedent B	Ever in II C	10.1	Man Danes		20832	anife Van an Na		ed Sta				
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No. 1 Yes, Give Year or Dates:			lf Yes, sped	,	exican, Puerto	ecify Yes or No- Rican, etc.)	В	Black, White, city: Whi	etc.			
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Maryland	d 2 sho th and 7 is m traum		19a. Informant's Name/Relationship (Beth Rattner Rer				_		lumber or Rura Stree	al Route Numbe t, Olne		-	Code) 832			
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<u><u>E</u></u>	Page nent o ant: If ury or		1 Burial 2 □ Cremation 3 Under the state of the stat			-		netery	4/1	9/07	Germa	ntown,	Md.			
Baltimore,	permit. Departimonts Imports any Inj		21. Signature of Funeral Service Lice	nsee Barher			Murie		Barber 1	Funeral Laytons		Mđ.	20882			
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<u>.</u>	that the		Part II. Other significant conditions	contributing to death bu	ıt not result	ting in the ur	nderlying ca	ause given in	Part I.	23e. Did to	bacco use co	ontribute to th	e cause of death?			
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2 ☐ Medical Exa	nysician: To the best of miner: On the basis of and manner sta	examination	ledge, death on and/or in	vestigation	, in my opinio	n, death occurr	and due to the d red at the time, d	ause(s) and late and plac	manner as st ce, and due to	ated. the cause(s)			
	_	Σ	29b. Signature and title of certifier	mille	9			License nun		2	473	ned (Month,				
	0	-	11000000					4005	8032		Upr	il 16	,2007			
			30. Name and address of person who Cynthia M. Willi		aui (item 2			aster M	Mill Ro	ad, Rocl	kville	, Md.	20855			
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 7 2	32 degistra	ır's Signatu	ire	Octo 9	(

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** April 14, 2007 12:55 a ^M James Perry Russell /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Lorien Nursing & Rehabilitative Ctr. Mt. Airy Carroll 8. Date of Birth (Month, Day, Year) Mar 4, 1917 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 MM 2□ F 90 548-12-5848 Director Oklahoma Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d, Inside City Limits 10a. State 27 is marked other then "natural", or iteme 23a or 28e-f ehow treumatic event, the Mudical Examinar minual ke motified at Westminster Carroll 1XYes 2 □ No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1197 Long Valley Road 21158 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WWI. 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Depurtment of Health and Mental Hygiene. In Inforciant: If Item 27 is marked other then "natural", or item any injury or other treumatic event, the Medical Examinat. Once. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WWII 1 ☐ Yes 2 No Specify: by Specify: white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laid Pipeline Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gussie Sheppard Ode Russell ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1197 Long Valley Road, Westminster, MD 21158 Linda Essenmacher, daughter 20b. Place of Disposition (Name of South 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4/17/2007 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home M01191 91 Willis Street, Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part \(\) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. mmediate Cause (Final Physician neumonia disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine use as the burial-transit The law requires that the death certificate be executed erTENSION resulting in death) Last Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? įō Month Day 4 ☐ Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∰Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 No 2 No Division of Vital 1 Tes t 🗆 Yes Hospitel or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Nursing Home 5 Residence 6 Other (Specify) his After this funeral c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 24 hours after death.

Funeral Director: A М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier termitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 ţ 29c. License number 29b. Signature-and title of sertifier 0 WIST STIVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 807 10/ 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

2007

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2007 Riley Louisa Elsie 2150 April 10 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Carrol1 Westminster Carroll Hospital Center If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1□ M 2 🗆 F 90 013-18-5012 Feb 2 1917 Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Sykesville 1 TYes 2 No Carrol1

ESFE KILEY Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760, 1 - For State Registrar

Physician

/Medical

Examiner

Funeral

Director

larylan show ed at	ž	10a. State MD	10b. County Carroll		10c. City, Tow Sykesy							10d. Inside City Limits 1 ☐Yes 2 ☐ No
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with the sa or 2 the m	Dir	10e. Street and Nut	_{mber} rd Avenue	A-103			10f. Zip Code 21784			US. Ch		ountry?
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and 2 shouealth and N 27 is mai			ame/Relationship (cher (neg	Type. Print) hew-in-1av				and Number or R				Zip Code)
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iyslcian: lis certific director,	To Be (25. Was case reference examiner? 1 ☐ Yes 2 ☑	rred to medical	Hospital: 1 Inpatie	ent 2□ER/Ou	utpatient	3□ DOA Oth	26. Place of Dener: 4 ☐ Nursing	eath (Check only		6 □Other (Spe	ecify)
To the Hospital or Attending Physician: The within 24 hours at er dea h. To the Funeral Director After this certificate completely filled in by the funeral director, pag		27. Manner of Dear	5 ☐ Pending investigation			Time of Injury	28c. Inju Wo	ry at rk? Yes 2 ☐ No	28d. Describe			
ital or Att irs af er de ral Direct lled ir by 1	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	building, et	c. (Specify)				City or To	own, Stat	e)	tural Route Number,
the Hosp nin 24 hou the Fune npletely fi	Medical	29a. Certifier (Check only one)	2 Medical Exa	nysician: To the best miner: On the basis o and manner sta	f examination ar	nd/or inv	estigation, in my	opinion, death occ	curred at the time	e, date ar	nd place, and du	e to the cause(s)
و ع الج ع	2	29b. Signature and	title of certifier	. Man,	mo		29c. Licens	se number		29d. Da	ate signed (Mon	tn, Day, Year) کی دے ک
v 5		30. Name and add	ress of person who	completed cause of d	eath (Item 23a)	(Type, P	rint)	. 61	- D-	/	Perstan	th, Day, Year) 2 3 2 7
Sta Registr		31. Date filed (Mor.	nth, Day, Year)	32. Registr	ar's Signature		(V .					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4/18/07, per FHDB entiticate of Death Registrar #10b #10c Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Year April 14, **Physician** 11:15 AM Mitchell B. Reiner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Keswick Nursing Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day,) Jan 8, 1 9. Birthplace (State or Foreign Country) NJ 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1√2 M 2□ F 79 156-20-3195 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10a. State r then "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 1:3 Yes 2X No Funeral Director MD Baltimore City Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 USA 3723 Washington Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status filed within 72 hours after 1\(\tilde{\text{T}}\) Yes 2 \(\text{No}\) No If Yes, Give Year or Dates:1945-47 1 Never Married 2 Married 1 Yes 2 No Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 4 Contractor Salesman ant of Health and Mental Hyg 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Flora Freeman Benjamin Reiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Reiner/wife 3723 Washington Avenue Baltimore, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Himportant: If its any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory | 04/18/07 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Servi 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TEREBRO VASCULAR **Physician** disease or condition resulting in death) LEOUS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transl Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by caroer with 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1□ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Qo Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 Tes 2 No investigation the Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled in the completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) oleted cause of death (Item 23a) (Type, Print) iulknerms 6565 N. Chaulo St 32. Resistrar's Signature Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 98 **Physician** George H.D. Rinehart April 2႘ဗီဗီ7 11:31 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours XXM 2 F 78 Yrs. April 29, 109-20-0959 1928 New York Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at Maryland Anne Arundel 1√2 Yes 2 No Annapolis Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 419 3rd Street 21403 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No White Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Editor Publishing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stanley M. Rinehart, Jr. Mary Doran 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anne Rinehart/wife 419 3rd Street Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Baltimore Crematory 4/13/2007 Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myocardial Infarction Physician immediate disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Esophageal carcinoma 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed COPD- oxygen dependent 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has autopsy page certificate 1☐ Yes 20XNo Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XER/Outpatient 3 DOA ို 1 ☐ Yes 2X No 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: or Attending 5 ☐ Pending investigation (Month, Day Year) 1 X Natural Injury 1 ☐ Yes 2 ☐ No s after death.
I Director; A 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled Mccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, within 24 hours a

To the Funeral I

completely filled

> 2 State

Registrar

Dr. Joseph Friend 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D17965

April 13, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

116 Defense Highway Annapolis, Maryland 21401 32 Registrar's Signature

APR 13 2007

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			For State		State of N	/larylan	-	artment of I rtificate of	Health and Death	Mental Hy		275 275 275 WHI	11010
	.6 ts		Registrar 1. Decedent's Name (F	irst, Middle, Las	st)			- Inouto or	Douili	2. Date of De		6. U J /	3. Time of Death
	Physici /Medic				Y SWARTZ					APRIL I		2007 Year	8:30 A ^M
	Examir	er	4a. Facility Name (If no			er)		4b. City, Town,	or Location of Dea	ith	4	c. County of Death	COMEDN
			5. Social Security Number			Age (In yrs. I	ast birthday)	If Under 1 Year	OLNEY If Under 24 Hrs	s. 8. Date of Bi	rth	Q Right	GOMERY place (State or Foreign
Ш	Funeral Director		172-20-556	1	M 2□F	85	Yrs.	Months Days	Hours Mir	02/25/	a <i>y, Y</i> ea L 922	r) Cou	PA
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	arylar show d at	-		b. County		Tue. City	, Town or Lo	cation					10d. Inside City Limits 1X Yes 2 □ No
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	with is or it be n	Funeral Director	3330 NORTH		E MODID	et ud #	617		906		rog. c	U.S.	•
	ns 23	ıera	11. Marital Status	LEIDON	12. Was Decede	nt Ever in U.			Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No	D-	14. Race - Ameri	can Indian,
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by Fur	1 ☐ Never Married 3 ☐ Widowed 4 ☐		Armed Force 1 X Yes 2[If Yes, Give Year or Date:	No		If Yes, specify Cui 1 ☐ Yes 2 🗓 No		erto Hican, etc.)		Black, White, Specify: WI	etc. HITE
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and	ould be fil Mental H arked oth atic even	Be	17. Father's Name (First ABRAHAM SW)				MARIE S	ame (First, Middle	e, Maide	en Surname)	
Σ	should I ind Men marke	2	19a. Informant's Name		Type Print)		10h Maili	na Addraee /Strae			har Cit	y or Town, State, Zij	n Code 120006
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Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signators of Funer	al Service Licer			Ë	2. Name and Addi DWARD SA	ess of Facility GEL FUNE	RAL DIRE	CTI	ON, INC.	
	HO 2 6 0		23a. Part1. Enter the	discoss or com	plications that caus	and the death		091 ROCK	VILLE PI	KE <u>,</u> ROCK	VIL	LE, MARYL	AND 20852 Approximate
			shock, or heart fa	ailure. List only	one cause on each	line.	i. Do not en	ter the mode or dy	ing, such as cardi	ac or respiratory a	arrest,		Interval Between Onset and Death
3	Physician /Medical		disease or condition resulting in death)		a. CONGEST	IVE HI		AILURE					DAYS
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	cuted nd ransit	Examiner	Cause (Disease or injuthat initiated events	ry 1	C								
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Division	I or Atte after de Directe	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place of	injury - At ho etc. (Specif	ome, farm, st	reet, factory, office)	28f. Location City or To	(Street own, Sta	and Number or Rui ate)	al Route Number,
	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	Medical C				s of examina						e(s) and manner as and place, and due	
	To th withir To th comp	Me	29b. Signature and title	e of certifier	p Pla	Ae.		29c. Licer	D0057630	0		Date signed (Month	-
	01		30. Name and address	of person who	completed cause of	of death (Item	23a) (Type.	Print)					
	,		DR. ANURAI						SUITE 20	09, SILV	ER S	SPRING, M	D 20902
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Ł	Examin	-	4a. Facility Name (If not institution, give st		4 - 10	4b. City, Town, or Lo			4c. County of Dea				
			Hebrew Home of Great 5. Social Security Number 6. Sex		LOII . last birthday)		If Under 24 Hrs a	Date of Birth	o Rir	thplece (State or Foreign ountry)			
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	88a-f	ecto	10e. Street and Number	, , ,		10f. Zip Code		100	. Citizen of What Country?				
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	na 23	Funeral Director		2. Was Decedent Ever in	U.S. 13.	Was Decedent of Hisp	panic Origin? (Specif	y Yes or No-	14. Race - Am	14. Race - American Indian, Black, White, etc.			
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D	other ent,	Be C	17. Father's Name (First, Middle, Last)			1	8. Mother's Name (F	irst, Middle, Ma	aiden Sumame)				
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itama 23a or 28a-f show any injury or other traumatic event, Ira Madical Examinar must be rudified at once.		19a. Informant's Name/Relationship (Type Charles Sommerfield			ng Address (Street and SW 21 Terr				Zip Code)			
ē,	s 1 an f Heal ftem 2 other		20a. Method of Disposition		Place of Dispo	osition (Name of matory or other place)	Date	9 20	Oc. Location - City or	r Town, State			
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7	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	o cause on each line. Out to (or as a const	1171	HYPE	FRTEN	1510	N	Interval Between Onset and Death			
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.O. Box	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	ital death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of do Month	elivery Day Year			
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000	aw requir ss been si 2 should	ompleted						24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of			
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ita	sician: The certificate rector, pag	BeC	25. Was case referred to medical examiner?			10 -50	26. Place of Death (Check only one)				
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Division of Vital Records,	or Attending after death. Director: After in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe				f. Location (Stre City or Town,	eet and Number or f State)	Rural Route Number,			
J	Hospital	edicai Ce	29a. Certifier 1 V Certifying Phys (Check only one) 1 V Certifying Phys 2 Medical Examin	sician: To the best of my kner: On the basis of examand manner, stated.	nowledge, dea ination and/or i	th occurred at the time nvestigation, in my opi	e, date and place, and mion, death occurred	d due to the cau at the time, dat	use(s) and manner a te and place, and du	as stated. ue to the cause(s)			
	To the within 2 To the comple	Me	29b. Signature and title of certifier	11/1	1	29c. License	number	. 29	d. Date signed (Mor	nth, Day, Year)			
)	4		29b. Signature and title of certifier 29b. Signature 20b. Signa										
	4		30 Name and address of person who of	projected cause of death (I	(Type	Print) 2/14	ONTRO	SERL	Packu	ILLEMOZOS			
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DHMH 17 Rev 1/2001

State

Registrar

APR 1 7 2007

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 8:30 am Abraham Silver April 13, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 X M 2 □ F Yrs. Director 92 119-22-1127 June 17, 1914 New York Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f sh dical Ex-miner must be notifiled 1 ☐ Yes 2 No Director Maryland Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 14510 Homecrest Road 20906 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: þ Specify. 3 X Widowed 4 ☐ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Self-employed Refrigeration permit. Pages 1 and 2 should be filed Department of Health and Mental Hygii Important: If Item 27 is marked other any injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Max Silver Sarah Reine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Goldberg - Daughter 7724 Coral Colony Way, Lake Worth, Florida 33467 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Judean Memorial Gardens 4/15/2007 Olney, Maryland 21. Signature of Funeral Service Licer see 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Septicemia /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Colon Cancer 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2□ No 1 2 X No 1 ☐ Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) Hospice IPU 2 1 ☐ Yes 2 🔼 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this after death.

I Director: After the in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Certification; Injury at Work? 1 X Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours aft To the Funeral Di completely filled in Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Within To the 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) Delliams DO April 13, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia M. Williams, D.O., 6001 Muncaster Mill Road, Rockville, Maryland 20855 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar APR 17

DHMH 17 Rev 1/2001

		For State Registrar	(5)		ı ıvıaryıa		epartment of F			Reg. No	2007	14022
Physicia	- 60	1. Decedent's Name Syl		napiro					2. Date of D	15, Da	2007 Year	3. Time of Death 12:19 PM
/Medic Examin			f not institution	, give street and nui	mber)		4b. City, Town, o	Location of E	Death		. County of Death	nery
Funeral Director		5. Social Security N 579-46-7	lumber	6. Sex 1 ☐ M 2 ☐ ★	7. Age (In y	rs. last birtho	Monthe Dave	If Under 24 Hours	Hrs. 8. Date of B	lirth Day, Year)	9. Birthp 934 Was	place (State or Foreign ntry) D. C.
r 28a-f show	Director	Usual Residence of 10a. State Maryland 10e. Street and Nur	10b. County Montg	omery	10c.	City, Town o	ersburg			10g. Cit	tizen of What Coul	
perim. Tages I and Should be lined within 7.2 hours are locall with the maryand limportants if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	300 High 11. Marital Status 1 □ Never Marr 3 🕅 Widowed	ied 2□ Marri 4□ Divorced	If Yes, Gir Year or D	edent Ever in orces? 21 No ve		13. Was Decedent of H If Yes, specify Cubi	ispanic Origir an, Mexican, F Specify:	n? (Specify Yes or N Puerto Rican, etc.)		Specify:	can Indian, etc. White
ygiene. rer than "nat t, the Medica	Completed	Elementary/Second 12 Year	ondary (0-12) I'S	College (1-4or 5+)	- (G	ecedent's Usual Occup Give kind of work done ife. DO NOT use retired sistant Mai	during most o i) nager		Hon	ne Improv	•
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and 2 shi lealth and m 27 Is m her traum		19a. Informant's No Lyn Chie	t - Dau		look	103	Mailing Address (Street Driscoll)	Nay, G	or Rural Route Num aithersbu Date	rg, N	Maryland	20878
tment of H tant: If ite		4 ☐ Donation	☐Cremation 5 ☐ Other (S		State	cemetery,	Lebanon	4.	/17/2007	Ade	ocation - City or To	ryland
Depar Impor any Ir		21. Signature of F	aven)			Danzansky 1170 Rock				Chapels, le, Maryl	Inc. Land 20852
hysician /Medical Examiner		23a. Part1. Enth r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Gallbladder Cancer Due to (or as a consequence of):										
hysician and the burial-transit	edical Examiner											
. நெள்	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 23d. Date of the past 12 months? 1 □ Yes 2 ▼ No 4 □ Pregnant at time of death 5 □ Other (specify)								23d. Date of deliv Month	ery Day Year	
n signed by	by	Part II. Other signi	ficant condition	ons contributing to d	eath but not	resulting in t	he underlying cause giv	en in Part I.		_	_	the cause of death?
icate has bee	Completed								pe	as an topsy rformed?	prior to co	opsy findings available impletion of cause of
is certif	o Be	25. Was case reference examiner? 1 ☐ Yes 2 ☒		Hospital:	Inpatient 2	ER/Outp	atient 3 DOA Oth	or:	f Death (Check only ing Home 5 ☐ Re		6 X ☐Other (Speci	fv) Hospice
within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification: T	27. Manner of Dead 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide	th 5 ☐ Pendin investig 6 ☐ Could r	gation	th, Day Year		ury Wor		28d. Describ	e how inju		
To the nospinal or Australia, within 24 hours after death. To the Funeral Director: After completely filled in by the funer.		4 ☐ Homicide 29a. Certifier	determ	build	ing, etc. (Spe	ecify)	death occurred at the ti	me, date and	City or 1	own, Stat	'e)	
in 24 ho	edical	(Check only one)		Examiner: On the b			or investigation, in my	opinion, death		e, date ar	nd place, and due	to the cause(s)
Solution (1)	M	29b. Signature and	this of certifier		elle	mo	29c. Licens	5803	-	ay	ate signed (Month, Orcl 16,	,2007
4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia M. Williams, D. O. Montgomery Hospice Rockville, Maryland 20855										
Sta Registr	_	31. Date filed (Mor	oth Day Year)		Registrar's Si	gnature	Coast 1	1,	<u></u>		· · · · · · · · · · · · · · · · · · ·	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ĭ3, Roslyn Lepow Sher April 2007 9:16 P. M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) New York Nov. 3, 144-20-8907 89 1917 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Chevy Chase Maryland Montgomery Y Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8100 Connecticut Avenue, Apt. 319 20815 U. S. A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health Care Elementary/Secondary (0-12) College (1-4or 5+) 5+ Microbiologist Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman Lepow Mollie Rutchik 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin ALAN Sher Son 11404 Toulone Drive, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) 4/17/2007 Falls Church, Virginia National Crematory 21. Signature of Funeral Service Licenses Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the plath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) d Due to (or as a consequence of) neumania Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) orgeline Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ramous 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performe 2PM 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

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Physician:

Hospital or Attending Division

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Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show dical Examiner must be notified at

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Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tant: If item 27 Is marked other th ilury or other traumatic event, the

Department of Health Important: If item 27 any injury or other tr

Funeral

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Completed

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72 hours after death

burial-transit physician s the burial for use þ page 2 should funeral director. this After 1

Physician/Medical

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Medical Certification:

examiner' 1 Yes 2 No 27. Manner of Death 1 Natural

2 Accident

3 Suicide

(Check only one)

30. Name and addre

5 ☐ Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

of person who completed cause of death (Item 23a) (Type, Print)

w

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) emocny Blud, Beitzeda, Nos 2881

31. Date filed (Month) Day, Year)

2007 7

Registrar's Signature

6320

Registrar

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #17,18, perInf, C869, 7/30/07CErtificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Sanchez April 13, 2007 9:37 Domingo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1 X M 2 □ F Yrs. 96 El Salvador 219-33-1164 Director March 19, 1911 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County show r 28a-f show notified at 1 ☐ Yes 2 X No Director Hyattsville Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number an "natural", or Items 23a or Medical Examiner must be I 3511 Madison Place 20782 El Salvador Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No ģ 3 Widowed 4 Divorced El Salvadorian White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) the Clothing 6 Uniform Manufacturer nd 2 should be filed walth and Mental Hygier 27 Is marked other the traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cristina Jose Sanchez Lopez Gabino Sanchez Christina Lopez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tran Gilberto Sanchez - Son 3500 Bryson Street, Greensboro, North Carolina 27405 20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland National Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 4/17/2007 Laurel Maryland Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the detth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner lumor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last to (or as a consequence of) Examine be executed emia sician and burial-tran Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy for Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9⊡Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA 2 this funeral 28a. Date of Injury 27. Manner of Death 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ospital or Attend hours after death. Ineral Director: / 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide Hospital 24 hours a Two certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Padma Chirumamilla, M.D., 7600 Carroll Avenue, Takoma Park, Maryland 20912 32. Bigistrar's Signature 31. Date filed (Month, Day, Year) State APR 17 2007 Registrar

	•	Stanley Sanders	
Division of Vital Records, P.O. Box 68760,	**	Baltimore, Maryland 21215-0036	
al or Attending Physician: The law requires that the death certificate be executed is after death. In Director: After this certificate has been signed by the attending physician and add in by the funeral director, page 2 should be detached for use as the burial-transit	Physicia /Medica	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or Iteme 23a or 28a-f ehow any injury or other traumatic event, the Medical Examiner must be notified at	

Stanley H. Sanders, Sr. A. Facility Name (if not institution, give streat and number) A. County of Death A. County A. County of Death A. County A. Count		1 - State Registrar	Cei	rtificate of L	Death	Reg. No	<u> </u>	140						
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Social Security Number California Cali				4h City Town or		111111111111111111111111111111111111111								
Security Number Cales Ca	er		1	40. City, Town, or	Storio in Dealin	4c. County of Death								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** April 2007 P^{M} 15, 3:05 KATHRYN WILHELMINA STAMBAUGH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Carrol1 Westminster 8. Date of Birth (Month, Day, Feb. 2, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Hours Days 1 ☐ M 2 😾 F Maryland 80 Yrs 220-18-3222 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County "naturel", or Iteme 23a or 28e-f ehow Pages 1 and 2 should be filed within 72 hours after death with the Maryla nant of Health and Mantal Hyglene.
and if Health and Mantal Hyglene.
and if if it is not ked other than "naturel", or liteme 23a or 28e-1 ehou ury or other traumatic event, it is the lited at ury or other traumatic event, it is the lited at 1 Yes 2 No Directo Maryland Frederick Thurmont 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21788 303 Old Oak Place by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Cashier 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Emma Mort George Marshall Mentzer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6508 Springwater Court #3403, Frederick, MD 21701 Susan Fitzgerald / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or once. Apples Church Cem. 4/19/07 4 ☐ Donation 5 ☐ Other (Specify) Thurmont, Maryland of Fureral Service dicense 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 21. Signatu 615 EAST MAIN ST., THURMONT, MD 21788 Ded. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Respiratory tan **Physician** /Medical Due to (or as a consequence of): Examiner neumonia Sequentially flet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine VA The law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical ding pt esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? Month ŏ Day 4☐Pregnant at time of death signed by the at d be detached to 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 No certificate 1 Yes Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medicat 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 No 2 ER/Outpatient 3 DOA 1 Yes this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 -Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death | Director: / d in by the f 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide in by 4 \ Homicide within 24 hours a To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier A39502 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westwinster MIN 2157 E Mainst osain

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 1 8 2007

Baltimore, Maryland 21215-0036

Box 68760.

Records, P.O.

egistrar's Signature

Ammended #10f & #12 per f.d. WSH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2007 **Physician** 9:20 A M 12, April Vaughn Brooks Sparrow /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Greater Baltimore Medical Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 XM 2 ☐ F 224-28-8340 May 12, 1918 Virginia Director 88 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ∐Yes 2**x∏x**No Be Completed by Funeral Director MD Baltimore Randallstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or; any injury or other traumatic event, the Medical Examiner must be nonce. 21133 21136 3830 Brownhill Rd United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. 1944–1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Specify: White 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12th Train Dispatcher PA Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louella Rew Colie E. Sparrow 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis J. Sparrow 3830 Brownhill Rd. Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 urial 2 □ Cremation 3 □ Removal from State 4/16/2007 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD Lake View Mem Park 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Burrier-Queen Funeral Home and Crematory, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiae or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 3 days **Physician** Due to for as a consequence of) premonia /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to for as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician ar Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed' 2 1 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Depatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 Matural N/A 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, pegistrar's Signature State Registrar APR 1 3 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April **Physician** 12, 2007 Pauline Stevens 4:25am M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sun Valley Assisted Living Carroll Westminster If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) July 5, 19 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F 1910 231-62-0367 96 VÁ Director Usual Residence of Decedent Pages 1 and 2 should be tiled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Carrol1 Sykesville 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 320 Anna Lane 21784 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Receptionist Clerical 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stonewall Jackson Wingfield Mary Bullock ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine W. Molz (Daughter) 320 Anna Lane, Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State All County Cremation 4/13/2007 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HATCHT FUNERAL HOME & CHAPEL, P.A. Sykesville, MD 21784 (410)-795-1400 (Box 195) Page Haught Heubert 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final 4smotom 2 Physician bdomin2 reer disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) ed by the a ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an s certificate has birector, page 2 s autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir Medical Certification: To 27. Manuer of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3

State Registrar

31. Date filed (Month, Day, Year) APR 1 200

Anel.

29b. Signature and title of certifier

30. Name and address of person



who completed cause of death (Item 23a) (Type, Print)

29c. License number

00059943

29d. Date signed (Month, Day, Year)

April (2,200)

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2 Date of Death 3. Time of Death Month Day April 10, 2007 0022 hrs **Medical Examiner** <u>Linda Susan Shellem</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Country)MD Months Days Hours Director 3/22/1948 59 217-50-7893 1 M 2 X F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ıny 10a. State 10b. County 1 Yes 2 X No 28a-f shov Anne Arundel Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21140 IISA 3028 Tarpon Rd. Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) If item 27 is marked other than "natural", or items her traumatic event, the Medical Exminer must be White, etc. Armed Forces? 1 Never Married 2 X Married Yes 2XX No White If Yes, Give Year Yes 2 X No specify: Specify: 4 Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Executive Office Manager Restaurant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lois Hornberger William David Jenkins Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3028 Tarpon Rd. Riva, MD 21140 Husband Patrick Shellem Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4/14/2007 Annapolis, MD Hillcrest Cemetery 4 Donation 5 Other Specify. 22. Name and Address of Facility gnature of Funeral Service Licensee Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 Part I. Enter the dise de, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Modical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Causs (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical signed by the attending physician a be detached for use as the burial -AMENDED UNPENDED Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of deliver IF FEMALE: 23b. Was decedent pregnant in the Year Live birth Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✓ No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, P.O. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been suneral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? 2 No ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Other₄ Nursing Home 5 Residence 6 Other Inpatient 2 V ER/Outpatient 3 DOA ပ 1 🗸 Yes 2 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 V Natural Division 1 Yes 2 No within 24 hours after death To the Funeral Director: completely filled in by the Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 10, 2007 O.C.M.E. MO -7-oiste 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Tasha Greenberg MD. strar's Signature 31. Date filed (Month State

DHMH 17 Rev 1/2001 **OCME 2006**

Registra

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			For	State of N	Marylan		artment of H			l Hygie	ene			
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State Registrar

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Maryland 21215-0036 $^{/}$	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23e or 28e-f show ery injury or other treumatic event, the Mailical Examinar must be notified at once.	by Funeral Director		ied 2∑ Married 4 □ Divorced	Armed Forces 1 ☐ Yes 2 🕅 If Yes, Give Year or Dates:	? INo		Yes, speci		Specify:	Puerto Ric	an, etc.)		ck, White	
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DHMH 17 Rev 1/2001

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>	with the a or 28e be not	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Cour				
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21215-0036	ours after death with the Marylar fel', or Items 23a or 28e-f show Examinar must be notified at	by	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 Y No If Yes, Give Year or Dates:		f Yes, specify Cuba	Specify:	Specify Yes or No- rto Rican, etc.)	Black, White,				
ر ا	72 hours "naturel",	leted	15. Decedent's E (Specify only highest gra		(Give	dent's Usual Occupa kind of work done of	during most of w	orking	16b. Kind of Business/Inc	dustry			
\(\frac{1}{2}\) \(\frac{1}{2}\)	withir iene. rthen	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4		DO NOT use retired memaken	,		Home				
	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then may injury or other treumetic event, in h. M. ADGE.	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Na	ame (First, Middle,	Maiden Sumame)	4.5			
ا چ		To	Eduard I. 19a. Informant's Name/Relationship (Dansereau	405 11-17			na Kirk	r, City or Town, State, Zip	0.41			
¥a 3			A. Orrell Saulsbu	** * *	i				igely, Maryl				
$N\!$	of Hea of Hea fitem rothe	,	20a. Method of Disposition 1 ☐ Burial 2 ☐ © remation 3 ☐	20b.	. Place of Dispo			Date	20c. Location - City or To				
	t. Pag tment tent: I		' 4 ☐ Donation 5 ☐ Other (Specif	fy)		Cremator			Dover, Dela	uare			
Bal	permit. Departr Importe any inje		21. Signature of Funeral Service Life	Mez.		Name and Address				1 21620			
			23a. Part1. Enter the pisease, or com	plications that caused the de					enton, Maryl rest,	Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition resulting in death) a Klonee Osphere Cause (Final disease or condition a Klonee Osphere Cause (Final disease or condition)										
	/Medical Examiner	i,	resulting in death)	Due to (or as a conse	equence of):	7		The same of the sa		1			
	*	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence of):				- 4	1821-7			
	cate be executed oblysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c									
8760,		al E	Totaling in doain, gas.	Due to (or as a conse	equence or):								
9	tificate ig phys as the	ledical	~ >	_ d									
.О. Вох	requires that the death certific een signed by the attending pl hould be detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year			
Division of Vital Records, P.	w requires that the de been signed by the a should be detached f	by	Part ii, Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.										
oce		Completed						24a. Was a autops	sv prior to co	psy findings available mpletion of cause of			
a R	rsicien: The law s certificate has b lirector, page 2 s								2 → 1 ☐ Yes	2 🗆 No			
Z.	Physicien: this certificated director, I	To Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2	□ FB/Outpatien	t 3 DOA Othe		eath (Check only or Home 5 ☐ Resid	ne) ence 6 □Other (Specif	iv)			
n of			27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)					ow injury occurred	77			
siol	Attending r death. ector: After you the fune	catic	2 Accident investigatio	n		M 1 []	Yes 2 No	006 1		75			
Divi	after of Direct	Certification;	4 Homicide determined		nome, farm, str cify)	eet, factory, office		City or Tow	treet and Number or Rura n, State)	u Houte Number,			
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one) 1	hysicien: To the best of my ki miner: On the basis of examin and manner stated.	nowledge, death ination and/or in	n occurred at the time vestigation, in my op	ne, date and place pinion, death occ	e, and due to the courred at the time, d	ause(s) and manner as s date and place, and due to	tated. o the cause(s)			
	To the To the Comp	M	29b. Signature and title of certifier			29c. License	number	200 2	29d. Date signed (Month,	Day, Year)			
T			11/11/16	17/1/ /hopen 102/18/ 3/17/07									
			30. Name and address of person who WILLIAM ROBINS,				RY, MD.	21804	4 .4.0000				
135		ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature								
DU	Regist MH 17 Rev 1/2	* war o'b	APR 1 8	2007	A A								

ORIGINAL

				ase Type or Pri					_		egible.		
			1 - For Amend Item State Registrar	23a,PtH per of	larylan ir.,806	7,05/24 Ce	ortment of l Oldho rtificate of	Health and N Death	/lental Hyo	giene Reg. No.2	007		:03
4	5	- *	1. Decedent's Name (First, Midd	lle, Last)					2. Date of Dea	ath Day	Year	3. Tim	ne of Death
	Physici /Medic		VERON	NICA LEE	ζ.		SPRIGGS		04	20	2007	20	09
	Examir		4a. Facility Name (If not institution				4b. City, Town, o	or Location of Death		4c. Co	unty of Deatl	า	
			WMHS-BRA	ADDOCK CAMPU	S		CUMBER	LAND		ALI	EGANY		
-	Funeral		5. Social Security Number	6. Sex 7. A 1 ☐ M 2 ☐ F		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	v, Year)	Co	untry)	ate or Fore
-	Director		215-44-9303 Usual Residence of Decedent	24		60 Yrs.			October (1946	M	D	
	and		10a. State 10b. County	/	10c. City	, Town or Lo	ocation					10d. Insid	ie City Limi
	sho sho	ō	MD 57 1 1			1						1🗶	Yes 2□1
	he N	Director	MD Washi	ngton	на	ncock	10f. Zip Code			10a Citizar	of What Co	untn/2	
	with t			le Durines			21750			USA	TOT WHAT OU	unitry:	
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	er de Item	Funeral	11. Marital Status	12. Was Deceder Armed Forces	s?	5. 13.	If Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puert	Rican, etc.)	13.	Black, White		11,
Maryland 21215-0036	J within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show the Medical Exeminer must be notified at	þ	1 □ Never Married 2 □ Ma 3 □ Widowed 4 ☆ Divorce	I If Yes, Give ⁴	: (140		1 □ Yes 2🏋 No	Specify:		Sp	pecify: W	hite	
0	72 ho natur ical	Completed	15. Decede	nt's Education est grade completed)		16a. Dece	dent's Usual Occu	pation during most of wor	kina	16b. Kind	of Business/l	ndustry	
21	e. an "r	e d	Elementary/Secondary (0-12)	College (1-40	r 5+)	life.	DO NOT use retire	ed)	ong				
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Þ	e filed al Hygi other vent, tl	Be C	17. Father's Name (First, Middle	e, Last)			•	18. Mother's Nan	ne (First, Middle,	Maiden Su	rname)		
lar	uld by Aenta	ToE	James Leon S	priggs				Eleanor	Sarah	Fink			
ary	d 2 sho th and 7 is ma trauma		19a. Informant's Name/Relation	ship (Type. Print)		19b. Maili	ng Address (Street	t and Number or Ru	ral Route Numbe	er, City or T	own, State, Z	(ip Code	
			C.Anette Bish	op/Sister		11703	3 Town Cr	eek RD Fl	intston	e,MD	21530		
Baltimore,	S = = 0		20a. Method of Disposition		20b. P		osition (Name of matory or other pla		Date			Town, Sta	le
E O	Pages nent of I int: if it		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 □Removal from Stat Specify)	eı			ory 04/23	3/2007	Cmi th	ah	MD	
量	nit. I artm ortar inju		21. Signature of Funeral Service		121111	LIISOUI	2. Name and Addr				 ,		
Ba	permit. Page Department of Important: If any Injury or once.			DALICIE		Gr	ove Fure	ral Home.	41 West				
	evel keri		23a. Part1. Enter the disease, shock, or heart failure. Li	r complications that caus	ed the death	n. Do not en	ter the mode of dy	ing, such as cardiac	or respiratory a	rest,	No LING E-		imate
			shock, or heart failure. Li	t only one cause on each	line.							Onset	and Death
Ì.	Physician /Medical		disease or condition resulting in death)	a. CHKU	Inc		HYTHMI	C				mon	11H3_
	Examiner			0.000	as a consequ		n Nici	2011				1/170	DI
3		<u></u>	Sequentially list conditions,	The state of the s	as a consequ	Contract of the Contract of th	K DISC	17.00				141	<u> </u>
_	ed isit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is it is a second or injury).	₹ Nuna			11 1711/					VIV	12/
Z _S	be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c. <u>01115</u>	LPES		LLITUS					TLI	KD
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687	physi the b	dica		d									
9 x	death certificate b e attending physic id for use as the b	Me	IF FEMALE:	00-16									
Box	ath c ttenc or us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 🗆 Feta	Ideath 3	Ectopic pregnanc	су		230	 Date of del Month 		Year
0	0 0	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant 9∐Unknown		eath 5	Other (specify)_						
P.(requires that the een signed by the	Phy	Part II. Other significant condit	liane contributing to dooth	but not ree	ulting in the	ınderlyina cause ci	von in Part I	23e Did to	nhacco use	contribute to	the cause	of death?
	res the signed be d		LUOIDO DEN 141A		. 14		Lremity -M	1/		Yes 2□	× .	3. Time of De 2009 atth Y 2009 atth Y 2009 atth Y 2009 atth Y 200	
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Š	aw r as be 2 sh	ple	AMPUTATION.	CONGESTIVE	HEY	ART F	AILURE.		24a. Was	an a	24b. Were au	topsy find	ings availa

within 24 hours after death.

To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 2 Certification: To Be Com

Division or Vital R

To the Hospital or Attending Physician:

3 Probably 4 ☐ Unknown

1□ Yes 26. Place of Death (Check only one) 4b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ X No

CHRONIC OBSTRU	CDUE
25. Was case referred to medical examiner?	C1,, V.D
examiner? 1 ☐ Yes 2 ☑ No	Hospital:
27. Manner of Death	28a. D
1 Natural 5 Pending 2 Accident investigation	n (i

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year)

Hospital: 1 | Inpatient | 2 | DOA 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a.	Certifier
	(Check only
	one)

3 ☐ Suicide 4 ☐ Homicide

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 30. Name and address of 8 of death (Item 23a) 29c. License number

29d. Date signed (Month, Day, Year)

Birthplace (State or Foreign Country)

10d. Inside City Limits 1X Yes 2 □ No

State Registrar

Medical

			Flease	Type of Printing					•		egibie.			
			1 _ For State	State of Marylan	•			and Mer	ıtaı Hygi	ene	007	14034		
			Registrar		Cen	ificate	of Death			g. Nơ	001	a Fire of Dooth		
	Physicia	an	1. Decedent's Name (First, Middle, Las		~ V				Date of Death Month	Day	Year	3. Time of Death		
	/Medic		tatrich		JOK				04	17	2007	la s		
	Examin	er	4a. Facility Name (If not institution, give	4 /	011	4b. City, To	own, or Location of	of Death		1	ounty of Death	\ \		
				4 Nursing	+Kenah	14112424	Year If Under	SVII	e	1	rede			
	Funeral		5. Social Security Number 6. S	□M 2XIE	Ven	If Under 1 Months	Days Hours	Min.	Date of Birth (Month, Day,	Year)		nplace (State or Foreign intry)		
	Director		QQ9-36-7937 1 Usual Residence of Decedent	77	/ 113.			Ma	rch 10	, 19	30 Vi	rginia		
	and and		10a. State 10b. County	10c. Cit	y, Town or Loca	ation			10d. Inside City L					
	Many f sho ed s	ō	Maryland Frederi	ck	Freder	ick			1 ⊠ Yes					
	28a-	Director	10e. Street and Number	CK	rreder	10f. Zip C	Code		10g. Citizen of What Country?					
	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. d other then "netural", or items 23e or 28e-f show event, it e Madical Examiner must be notified at	٥	526 Mary Street				21701		United States					
	eath	Funeral	11. Marital Status	12. Was Decedent Ever in U	.S. 13. W		nt of Hispanic Ori y Cuban, Mexicar	igin? (Specify	Yes or No-		. Race - Amer	ican Indian,		
•	fer de la company de la compan	표	1 ☐ Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 ∑No	i				an, etc.)	Black, White, etc. Specify: White				
3	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	11	☐ Yes 2	☑ No Specify:			Specify: WILLE				
9500-6121	2 bo	Completed	15. Decedent's E	ducation	16a. Decede	ent's Usual	Occupation done during mos retired)	t of working	1	6b. Kind	d of Business/I	ndustry		
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7	led wit tygien her th	5		4	Hoi	memak					n Home			
ğ	be filed stal Hygis od other event, II	Be (17. Father's Name (First, Middle, Last,)			18. Mothe	er's Name (F	irst, Middle, M	faiden S	lumame)			
<u>a</u>		P	Robert Wallace					thy Su						
Maryland 2	s 1 and 2 should f Health and Mer item 27 is merke other treumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street and Number	er or Rural R	oute Number,	City or	Town, State, Z	ip Code)		
	1 and 2 Health tem 27		Ellis Tonik / Hus	sband			treet, F							
o e	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □	Removal from State	Place of Disposi cemetery, crema	ition (Name atory or oth	e of ner place)	Date April		20c. Loc	ation - City or	Town, State		
Ĕ	Pages nent of int: If it iry or o		`4 □Donation 5 □ Other (Special	(y) Res	sthaven	Crem		2007		rede	erick,	Maryland		
a a	permit. Departn Imports eny inju		21. Signature of Funeral Service Lice		R ² €:	sthav.	Address of Facili	al Ser	vices,	Skl	kot Cod	y P.A.		
m	88 E 8 8		1///		950	01 Ca	toctin_M	ltn. Hv	y. Fre	der:				
			23a. Part . Enter the disease, o com shock, or heart failure. List only	plications that caused the deat	h. Do not enter	r the mode	of dying, such as	cardiac or re	spiratory arre	est,		Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	Trul	mone	uh	tibus	310				Onset and Death		
	/Medical		resulting in death)	a. Due to (or as a consec	uence of):	7		V				Jeans		
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	le be executed ysician and e burial-transit	Examiner	Cause (Disease or injury that initiated events c											
oʻ	an ar rial-t		resulting in death) Last	Due to (or as a consequence of):										
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89	The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the 1	Physician/Med	IF FEMALE:											
Box	th ce tendii r use	an/h	23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fete		Ectopic pre	gnancy			23	3d. Date of deli Month	very Day Year		
O. E	dea death	sici	in the past 12 months? 1 ☐ Yes 2 █ No	4□Pregnant at time of o 9□Unknown	leath 5	Other (spe	city)				WONE	Suy		
д О	at the by tl	h.	9 Unknown						OO - Did tob		a contributa to	the cause of death?		
ś	es th gned be de	by	Part II Other significant conditions	contributing to death but not res	sulting in the uni	derlying cai	use given in Part i	l. 	1 ☐ Ye	- 4	_	obably 4 Unknown		
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ပ္မ	law r as be 2 sh	ple	0						24a. Was ar autops	у	prior to d	topsy findings available completion of cause of		
Ě	The ate h page	Completed by							perform 1 ☐ Yes 2	ned?	death? 1 ☐ Yes	2 □ No		
ta	ien: artifica ctor,	Be (25. Was case referred to medical examiner?					e of Death (C	check only on	θ)				
≥	nysio	2	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 DO	Other: 4 N				Other (Spec	cify)		
Division of Vital Records,	ng PI fter ti nera		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		dc. Injury at Work?	!	I. Describe ho	w injury	occurred			
<u>0</u>	endi eath. or: A he fu	ati	2 ☐ Accident investigation			М	1 Yes 2							
Ĕ	r Att	Certification;	3 Suicide 6 Could not be determined		ome, farm, stre fy)	et, factory,	office	281	. Location (Sti City or Town	reet and 1, State)	Number or Au	iral Route Number,		
Ω	ital curs af													
Part										and manner as place, and due	to the cause(s)			
29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and models are an expected by the cause of the cau									signed (Monti	h, Day, Year)				
	To Wit		250. Signature and this of certifier			7	1715	11	e^	LP0	11 1-	ナコムヘユ		
,	1		1/1/1/20		00.1.77		1260	10	r	1110	-16 1	1 200 /		
	M		30 Name and address of person who	completed cause of death (Ite	m 23a) (Type, F	Jint)	/ AND		RED	M	0 2	1762		
			31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature	- h /	1100	- 1	3.00	/				
	Sta Regist	ate rar	APR 1 8 2	2007 Bayes	1. A									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. U 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Yeer **Physician** 10:27 AM Pril Madelene urner 200 /Medical 4c. County of Death 4a. Facility Name (If no institution, give street and number) 4b. City, Town, or Location of Death Examiner Rusty H -5-Acres Queen Lane Hune's If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 □ M 2 😿 F Months 28-1724 Hours Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23s or 28s-f show the Medical Exeminer must be notified at 1 ☐ Yes 2 ☑ No Director Dueen Anne's Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2/6 Funeral res Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1□Yes 2☐No Specify: Specify: Completed by 3 DWidowed 4 □ Divorced Black 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Residence WOVK rivate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ie marked John ၉ au Se Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar important: if item 27 ie any injury or other trac once. 20b. Place of Disposition (Name of cometery, crematory or other place)

Date

20c. Location - City or Town, State Valerie Coffer 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Mid Shore Cremation 4/16/07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hewry Funeral Home, F.A.

510 Washington St. Cambridge Maryland 21613

23a. Part Inter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (6n bective noling. heard Physician sus /Medical Due to (or as a consequence of): Examiner 48 HR10(C 11.108 1081 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. Il yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 132tes 2 No 3 Probably 4 Unknown Completed been beriosclarotic (CORT MOVASUNAR 1/2/6 6 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has autopsy performed? Yes 20 No certificate 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 ☐ Yes 2 ☐ NO 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1. Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: / 2 Accident nin 24 hours.
o the Funeral Directo. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Let Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 20s Cartifier (Check only

State

within ;

٥

29b. Signature and/title of certifier

ments

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be nent of Health and Mental

permit.

The law requires that the death certificate be executed

the Hospital or Attending Physician:

death.

Division of Vital Records, P.O. Box 68760,

DAFFIN LANZ daman 31. Date filed (Month, 32. Reg

30. Name and ress of person who completed cause of death (Item 23a) (Type, Print)

121

Registrar

609

29c. License number

D 5029

29d. Date signed (Month, Day, Year)

DEnton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 2140 April Evelyn Theresa Tippett 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Talbot Memorial astor Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 📉 F Yrs. 89 April 14 1918 Washington, DC 578-07-5164 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland | Caroline Ridgely 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 24169 Carrilyn Drive 21660 USA Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) plummer's union office machine operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental if Health and Menta item 27 Is marked Edwin O'Callaghan Melissa Williamson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Alexander/ niece 5930 Old Washington Road; Sykesville, MD 21784 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of the Important: If ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 04/20/2007 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PO Box 160; Greensboro, Maryland 21639 Approximate Interval Between Onset and Death Immediate Cause (Final 8515 Physician Urose resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) detached 2 🗆 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ should be into9 Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform certificate or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 hpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

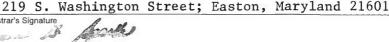
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ca completely within 2 and manner stated.

State Registrar 31. Date filed (Month, Day, Year) APR 19 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

Dennis M. DeShields, MD32. Registrar's Signature



29c. License number

29d. Date signed (Month, Day, Year)

Evelun

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Apr 24, 2007 2:40pm Juanita Virginia Thomas 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany Beverly Living Center of Cumberland Cumberland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sep 6, 1913 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex Wintry) 1 ☐ M 2 ☐ F 213-44-2024 93 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County MD 1√1Yes 2 No Allegany Cumberland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 220 Somerville Avenue Apt. 414 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: white 3X☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Rosa Shanholtzer Thomas Arthur A. Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 809 Kentucky Avenue MD 21502 Cumberland Raymond Thomas son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/28/2007 WV Levels Cemetery Levels ¹ 4 ☐ Donation 5 Other (Specify) 21. Signature Juneral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) lan Coronan Due to (or as a considence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 □Unknown 1 ☐ Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident

Priysician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

r than "naturel", or Items 23e or 28a-f show the Medical Examiner must be notified at

Completed by Funeral Director

Be

with the Maryland

filed within 72 hours after death

Hygiene.

other

Pages 1 and 2 should be filed vitnent of Health and Mental Hygientent: If item 27 is marked other to jury or other traumatic event,

permit. Page Department o Importent: If eny injury or once.

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Maryland

Baltimore.

Box 68760.

P.O.

Records.

Division of Vital

Examiner -transit burialattending physician for use as the buria ed by the a detached t signed t page 2 s certificate this After

death.

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funerel Director:

Completed by Physiclan/Medical Be 2 Certification: Medical

3 State 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OR SUNIL

6 Could not be determined

3 🗌 Suicide

29a, Certifier

4 Thomicide

(Check only one)

29b. Signature and title of certifie

GUPTA; 32. Segistrar's Signature

GAS KENT AVE, CUMBERLAND, MD 21502

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Dod33280

28f. Location (Street and Number or Rural Route Number, City or Town, State)

April 25,

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2007 April 14, **Physician** 9:37A. M Orpah Eve Wood /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery Himalayan Elderly Care If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours May 15, 1914 Virginia Months 1 □ M 2 🔀 F 92 016-14-0310 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a, State 1 ☐ Yes 2XNo Rockville Maryland Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20853 United States 14725 Janice Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1□Yes 2XNo Baltimore, Maryland 21215-0036 Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine Clevenger William Wesley Mayes 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Edds) 14725 Janice Drive Rockville, Maryland 20853 19a. Informant's Name/Relationship (Type. Print) Lauretta Shaak -daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State 20c. Location - City or T Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licer Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimer's Disease years **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 ca Physician/Medi IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
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spital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and "filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital of within 24 hours at To the Funeral D

Medical Certification: To 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification D09834 April 16, 2007 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
Barry Rosenbaum, MD 3720 Farragut Avenue Kensington, Maryland 20895

State Registrar 31. Date filed (Month, Day, Year)

1 7 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland /		artment of I rtificate of			giene leg. No.	07	14039
Ť	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Lori Ann Wood				2. Date of Dea		.00 7 ar	3. Time of Death 7:55A. M
)	Examin	36	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital		Laure		th		nty of Death	eorge's
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. I be protraint: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Y ceme	t Lel		metery 4	/18/2007 dt Funera		i, Ma	
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Ω̈́	pital or A urs after eral Dire		4 ☐ Homicide determined building, etc. (Specify)				City or Tow	n, State)		
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			30. Name and address of person who completed cause of death (Item 23a Abdul Momin Tak, M.D. 8860 Columb	ia 10		ay, #211	Columbia	, Mar	yland	21045
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Physicia	F	Registrar 1. Decedent's Name (First, Midd	dle.Last)		incate o	Deam			2.	Date of De	Reg. No. eath			. Time of Death
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al R an: T ertifica ttor, pi	Be C	25. Was case referred to medi					26.Pla	ce of Death						
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should	0	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatie		OA	Other ₄		Home 5		ence 6		Scene
1 of V ding Ph. After ti	Jn: T	27. Manner of Death 1 Natural 5 P.	E-OMEN	e of Injury h, Day,Year) D:	28b. Time of FOUND:	of Injury [2		ijury at Wor Yes 2 ∨	_ !<	28d. Descri Subject s			eu	
Division tal or Attendi rs after death. al Director: A	ertification:] = 5 P	vestigation Apr 8, 2		0650 hrs	reet factory	-			28f. Locatio	n (Street	and Numb	er or Rura	al Route Number, City
DIVIS at or A s after ed in b	ŧ	de	ould not be	Vehicle	ome, ram, o	root, ractory	,			or Town 09 Under	/atet2 c			
Divisior Hospital or Attend 24 hours after death Funeral Director:	ပ	4 Homicide 29a. Certifier 1 Certifying	Physician, To the he	set of my knowled	ge, death oc	curred at the	e time,	date and p	lace, and o	due to the c	ause(s) a	nd manner	as state	d.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 bours after death. To the Funeral Direct. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tran	Medical	(Check anly one) 2 Medical E	xaminer: On the basis and manner	of examination a	and/or investi	gation, in my	y opini	on, death o	occurred at	the time, d	ate and p	lace, and c	lue to the	cause(s)
To To corr	Me	29b. Signature and title of cert		J. G. C.		290		nse numbe	er					th, Day, Year)
		Date: ()	in La	DO. L			0.0	C.M.E.			Ap	ril 9, 200	J7	
_		30. Name and address of pers						0) = 16.° · ·	ND 01	201			
	jO	Patricia Aronica-Pol		tant Medical		111 P	enn	Street, B	aitimore	, IVID 21	201			
S Regis	tate trar	A D D	6 2007	Registrar's Signati	y da	od.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				For State Registrar	State o	f Marylar	,	artment of H		, ,	jiene	17	
				Decedent's Name (First, Middle, L.)	ast)	·.··				2. Date of Dea		0 1	3. Time of Death
_		Physici /Medic		C:	Lay Work	man				april	Day	Year	551 PM
		Examir		4a. Facility Name (If not institution, g	ive street and nu	mber)		4b. City, Town, or	r Location of Death	1	4c. County	of Death	
_				Harford Memo:		<u> </u>			e de Gra			Harfo	
		Funeral		5. Social Security Number 6. 177-30-7717	Sex 1XIM 2□ F	7. Age (In yrs.	last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	, Year)		lace (State or Foreign try)
		Director		Usual Residence of Decedent		71	113.			April 1	3,1936	West	Virginia
		show		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation				10	0d. Inside City Limits
		Mar Ba-f st	tor	Maryland Cec	il	i		Port	Deposit				1 ☐ Yes 24027No
		or 28	Director	10e. Street and Number				10f. Zip Code		1	10g. Citizen of	What Coun	try?
		ath w		96 Theodore Road					21904			.S.A.	
		er de	Funeral	11. Marital Status	Armed Fo		J.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rac Bla	e - America ck, White, e	
	36	ours after death with the Man el', or Items 23a or 28a-f sh Exertivet inust be nutified	by F	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	If Vac Gi	ve ates:1955	-56	1 ☐ Yes 2 ☑ No	Specify:		Specif	<i>r</i> : ,	White
	21215-0036		ted	15. Decedent's	Education		16a. Dece	dent's Usual Occup	ation		16b. Kind of B	usiness/Ind	dustry
	215	d within 72 hu piene. r than "netu I're Meulca	Completed	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	during most of work d)				n Trucking
7		e filed will Hygier other th		Eight Years			T	ruck Driv					, Maryland
VORKMAN	Maryland	0 to 0	Be	17. Father's Name (First, Middle, La: James P	. Workma	ın			18. Mother's Nam	e (First, Middle, . Mahala E		18)	
8	Z	2 should be and Menta Is marked aumatic ev	ပ	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street a				State Zio	Code)
R		d tha		Rosetta Workman	(wife)		1	eodore Ro			-		
3	Je,	s 1 and 2 of Health Item 27 I		20a. Method of Disposition			Place of Dispo cemetery, crer	sition (Name of natory or other place		Date	20c. Location	City or To	wn, State
W. Common	altimore,	Pages nent of I ant: If Its ury or o		1 N Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec		State		orial Garde		.8/07 E	Bel Air	Mar	yland
	Balt	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Lic	ensee	END		2. Name and Addressee A. Pat		Son Fun	neral Ho	ome, 1	P.A.
				23a. Part1. Enter the disease, or co	mplications that of	aused the deal	th. Do not ent	erryvillo er the mode of dyin	g, such as cardiac	nd 2190 or respiratory arr	3-0766		Approximate
	1	Pnysician		shock, or heart failure. List on Immediate Cause (Final disease or condition	y one cause on e	ach the.	arati	no sclen	to	Della	Para	1	Interval Between Onset and Death
	ı	/Medical		resulting in death)	a. The to	(or as a consec		winder	uc Lan	au von	erceo u	sease	
rgw	1	Examiner	_	Sequentially list conditions,	t	,							
,		pet Jisit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quence of):						
	<u> </u>	e be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):					-	
	8760,	ate be executed hysician and the burial-transit	dicai		d								
	9		Aedi	IF FEMALE.							16		
	Вох	eath certific attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		tcome of pregnation		Ectopic pregnancy				e of delive	ry Day Year
	O. E	or Attending Physician: The law requires that the death certific death. Director: After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as	by Physician/Me	1 Yes 2 No	4□Pregr 9□Unkn	nant at time of o own	death 5	Other (specify)			ivic	1101	Day real
	Ρ.	es that the de gned by the be detached	Ph	Part II. Other significent conditions	contributing to d	eath but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use cont	ribute to th	e cause of death?
	ds,	uires Isign Ild be	d b	None	,			, ,		1 🗆 Y	es 2 No	3 Proba	ably 4 []Unknown
	S	s been s	Completed							24a. Was a	in 24b.	Were autop	osy findings available
	Re	The lar	omp							autops	med?	prior to con death?	npletion of cause of
	ital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical		-			26. Place of Deat		*		2,410
	1	Physic this ce al direc	To E	examiner? 1 X Yes _ 2 □ No	Hospital:	Inpatient 2	ER/Outpatien	it 3□ DOA Othe	er: 4 🗌 Nursing Ho	ome 5 Reside	ence 6 Oth	er (Specify)
	n 0	ding Physician: h. After this certific funeral director,		27. Manner of Death 1 ■Natural 5 □ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	Work		28d. Describe ho	ow injury occur	ed	
	sio	vttendii death. ctor: A y the fu	cati	2 Accident investigati	ho -				Yes 2□No				
	Division of Vital Records, P.O.	spitel or Attend ours after death terel Director: , filled in by the f	Certification:	4 Homicide determine	d 28e. Place buildi	of Injury - At hing, etc. (Specia	ome, farm, str fy)	eet, factory, office		28f. Location (St City or Town		er or Rural	Route Number,
		To the Hospitel within 24 hours a To the Funerel Completely filled	Medical (29a. Certifier (Check only one) 1 Certifying F	aminer: On the b	best of my kno asis of examina ner stated.	owledge, death ation and/or in	n occurred at the time vestigation, in my op	ne, date and place, pinion, death occur	and due to the cared at the time, d	ause(s) and ma ate and place,	nner as sta and due to	ated. the cause(s)
		To th withir To th comp	M	29b. Signature and title of certifier	1 .1.	10		29c. License		2	9d. Date signe	d (Month, E	Day, Year)
				Bernarch Mu	ma MIL	ME		Mol.	4206	1	epid	15,2	007
		9		30. Name and address of ers in wh	cula MI	of death (Iter	m 23a) (Type,		IT DOMA	DE: A	I AK C	210	1 km
		Sta	te	31. Date filed (Month, Day, Year)	(N) / N U 32. P	DNE legistrar's Signa	ature /	INVERTOR	LE NUMB	DEL 1	IK 1.A	CXIU	13
		Registr		APR 1 7 2007	State	w St.	6034						

DHMH 17 Rev 1/2001

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			For State Registrar		State of	of Maryla		artment of H rtificate of I		-	giene Reg. No.	007	14042
370	p.		Decedent's Name	e (First, Middle,	Last)					2. Date of De	ath	V	3. Time of Death
	Physicia /Medic	-	Mary	Mace V	Webster					April	13	2007	10:55a. [™]
•	Examin		4a. Facility Name (/	,		ımber)		- 2, ,	Location of Death			nty of Death	
*				lenburn		1 - 2 - 2	1 11 11 6	Camb If Under 1 Year	oridge If Under 24 Hrs.	Data of Die		Dorche	
	Funeral Director		5. Social Security N 215–18–4	4952	6. Sex 1 □ M 2 🖾 F	7. Age (In yrs	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Aug. 7	ay, Year)	9. Birting Cour Mar	place (State or Foreign ptry) yland
	pug *		Usual Residence of 10a. State	f Decedent 10b. County		10c. C	ity, Town or Lo	ocation				1	0d. Inside City Limits
_	Maryland -f show iled at	ō	MD		nester			Cambr	ridge				1 XYes 2 No
T	the 28a-	rect	10e. Street and Nu	mber				10f. Zip Code			10g. Citizen	of What Cour	ntry?
5	h with	al D	117 G	lenburn	Avenue			2	21613		US	A	
)	after death with the or items 23a or 28a miner must be noti	Funeral Director	11. Marital Status		12. Was Dec Armed F	cedent Ever in orces?	U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No o Rican, etc.))- 14. [Race - Americ Black, White,	
30,		by Fu	1 ☐ Never Marr 3 ☐ W idowed	ried 2 Marrie	d 1 □ Yes If Yes, G Year or I	2 X No live Dates:		1 □ Yes 🏖 No	Specify:			ecify: wh:	ite
-0036	within 72 hours ene. than "natural"; he Medical Exa			15. Decedent's	s Education		16a. Dece	dent's Usual Occup	pation		16b. Kind o	f Business/In	dustry
2	hin 72 e. an "na Media	Completed	(Spec		grade completed) (1-4or 5+)	(Give	kind of work done DO NOT use retire		king	1		
7	ed wit ygien ier tha t, the	S	11					homemake		/P*		n home	
ana	should be filed within nd Mental Hygiene. marked other than imatic event, the Me	Be	17. Father's Name	(First, Middle, L ace Brol	•				18. Mother's Nam	ie (<i>First, Middie</i> E leanor		name)	
\geq	should and Men s marke umatic	은	19a. Informant's N				19h Maili	ng Address (Street				wn. State. Zir	Code)
<u> </u>	and 2 s ealth an n 27 is i er traui		Elaine 1			ıghter		Phillips				21613	,
ē,	s 1 ar		20a. Method of Dis	position		20b.		osition (Name of matory or other place		Date		on - City or To	own, State
aitimor	Pages nent of int: If its iry or o			☐Cremation 5 ☐ Other (Sp	3 □Removal fron <i>ecify)</i>	i State I	rcheste	er Mem. Pa	ark 4/1	6/07		idge, 1	
gair	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		21. Signature of Fi	uneral Service L	icensee		2	2. Name and Addre				Home 1 21613	P.A.
	12		23a. Part . Enter	the disease, or o	complications that	caused the de	ath. Do not en	ter the mode of dyir					Approximate Interval Between
	Physician		Immediate Cause	(Final	only one cause on	each line.	an Da	contra	1100	A M	van anav	6	Onset and Death
)	/Medical		disease or condition resulting in death)	on	aDue to	o (or as a conse	equence of):	yar e	_ Htel	1 64	400		
b	Examiner		Sequentially list or	anditions	b								
4	sit ed	Examiner	Sequentially list concause. Enter Undo Cause (Disease of that initiated event	erlying	Due to	or as a conse	equence ofj:						
_	cecute and I-trans	xam	that initiated event resulting in death)	r injury s Last	c	o (or as a conse	equence of):						
8/60,	cate be executed physician and the burial-transit					(,,						
200	ificate g phys	edic			a			/					
ROX	h cert ending	M/u	IF FEMALE: 23b. Was deceder			utcome pf preg		⊒Ectopic pregnanc	v		23d.	Date of deliv	,
n	e deat he att	Physician/Medical	in the past 12 1 ☐ Yes 2	☐ No		gnant at time of		Other (specify)	,			Month	Day Year
٦.	nat the d by tl letach	Phy	9 Unknow		l		esulting in the I	underlying cause giv	en in Part I	23e, Did	tobacco use	contribute to t	the cause of death?
ďs,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	þ	Partin Other aigh	Hypes	tensie	1	Journal of	g caace gi			Yes 2□N		s. A
Kecords		Completed		0 '						24a. Was	s an 2	4b. Were auto	opsy findings available ompletion of cause of
	sician: The law certificate has b irector, page 2 sl	mo				<u> </u>					ormed? 2 21 No	death?	2 No
VItal	sian: ertifica ctor, p	Bec	25. Was case refe examiner?	erred to medical		72			26. Place of Dea	ath (Check only	one)		-
or <	hysic this ce al dire	일	1 ☐ Yes 2/X	No.			☐ ER/Outpatie	IN 3 DOA		lome 5 Res			fy)
	ing P After (unera	on:	27. Manner of Dea	5 Pending	(Mo	e of Injury onth, Day Year)	28b. Time o Injury	Wo	ryat rk?]Yes 2∐No	28d. Describe	how injury oc	ccurred	
DIVISION	death ctor: , the (icat	2☐ Accident 3☐ Suicide	investig 6	ot be 28e Plac	ce of injury - At	home, farm, st	treet, factory, office	1163 2 110	28f. Location	(Street and N	umber or Rui	al Route Number,
<u>≥</u>	after after Direct	Certification:	4 ☐ Homicide	determi	ned buil	ding, etc. (Spe	cify)			City or To	own, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,		29a. Certifier (Check only		xaminer: On the	basis of exami		th occurred at the t					
	o the ithin 2 o the omplei	Medical	one) 29b. Signature an	d title of certifier	and ma	nner stated.		29c. Licens	se number		29d. Date si	gned (Month	Day, Year)
.	F≯Fö		> lid	e Attan	111			7)/	3259		04	/13/	07
ľ			30. Name and add	h hlll dress of person v	who completed ca	use of death (It	em 23a) (Type	, Print)	100		/	/ !	
			MAHB	WBA	Acces	TER,	503	BYRI	V ST	CAM	BRIDG	E, M	D-21613
		ate	31. Date filed (Mo	onth Day Year	6 2007 ^{32.}	Registrar's Sig	nature	Account 1					
	Regist	rar				The state of the s	1 300 3						

DHMH 17 Rev 1/2001

			1- State of Maryland /		artment of Ho <i>rtificate of E</i>		d Mental Hy	ygiene Reg. No. 200	7 14043
15	Physici /Medic		1. Decedent's Name (First, Middle, Last) MELVIN M. WHITE				2. Date of D Month April	Day Yeath 12 2007	• ()() A M
	Examir		4a. Facility Name (<i>If not institution, give street and number</i>) 6912 Reliance Road 5. Social Security Number 6. Sex 7. Age (<i>In yrs. last</i> 21 / - 18 - / 516 1		4b. City, Town, or Federa If Under 1 Year Months Days	1sbur	eath g Hrs. 8. Date of Bi (Month, D	4c. County of D Dorche irth Day, Year) 9.	ester Birthplace (State or Foreign Country)
	Director work	_	Usual Residence of Decedent 10a. State		cation		Sept.	20,1921 De	laware
	with the Mar a or 28a-f sh be notified	Funeral Director	10e. Street and Number	edera	alsburg			10g. Citizen of What	,
920	d within 72 hours after death with the Maryland glene. I'than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	þ	6912 Reliance Road 11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give		21632 Was Decedent of His If Yes, specify Cubar 1□Yes 22 No		(Specify Yes or N uerto Rican, etc.)	lo- 14. Race - A Black, W	merican Indian, /hite, etc. White
21215-0036	within liene.	Completed	(Specify only highest grade completed)	(Give life. L	dent's Usual Occupa kind of work done do DO NOT use retired) nry Contra	uring most of	working	Masonry	ss/Industry
Maryland	be file ital Hy id othe event,	To Be C	17. Father's Name (First, Middle, Last) Elzie Martin White 19a. Informant's Name/Relationship (Type. Print)	19h Mailir		Lyda	Murphy	e, Maiden Surname) ber. Citv or Town. Stat	a Zin Codal
Baltimore, Ma	t and 2 Health a tem 27 is		Loleta P. White/Spouse 20a. Method of Disposition 1 Rurial 2 Cremation 3 DRemoval from State 20b. Place ceme	6912 e of Dispos etery, cren	•	ce Rd	., Fede	ralsburg,	MD 21632
Balti	permit. Pages Department of Important: If is any Injury or o		21. Signature of Funeral Service Licensee Michael F- Goren	22	Name and Address N. Main	s of Facility F	ramptom Federals	Funeral Horburg, MD 2	me, P.A. 1632
THE CASE OF THE PARTY OF THE PA	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications that caused the death. It shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Each disease or consequence. Due to (or as a consequence cause of the conditions).	572 ce of):	W 9 & 12	, such as can	alac or respiratory	arrest,	Approximate Interval Between Onset and Death
x 68760,	ertificate be executed ling physician and e as the burial-transit	Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C						
.0. Box	that the death certifi ed by the attending detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death	eath 3□	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
Records, P.	requires een sign nould be	þ	Part II. Other significant conditions contributing to death but not resulting to Death Py N2	_	Hoderlying cause give		1_]Yes 2MNo 3□	e to the cause of death? Probably 4 Unknown
Vital Rec	The lar ate has page 2	Be Completed	25. Was case referred to medical			26. Place of I	— 24a. Was auto perl 1 Yes	opsy prior formed? death 252 No 1 □	
0	ling Phys n. After this funeral dir	은	27. Manner of De th 12 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Outpatien Time of Injury	t 3 DOA Othe	r: 4 \Basel Nursin	g Home 5 Res	sidence 6 Other (Se how injury occurred	Specify)
Division	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	al Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home building, etc. (Specify) 29a. Certifier 1 ★ Certifying Physiclan: To the best of my knowled.	dge, death	n occurred at the tim	ne, date and pl	City or To	(Street and Number of own, State) e cause(s) and manne	r as stated
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier	and/or in	vestigation, in my op	number	occurred at the time	e, date and place, and 29d. Date signed (M	due to the cause(s)
)			20 Name and addless of person who completed cause of death (Item 23	la) (Type,	Print)	22 20)74 \	4-16	200)
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 8 2007	N A	Analls	IN 60	AUZ 14	or form	11 173126

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		State of Maryland / Department of Health and M		9
	and the second	Registrar Certificate of Death Decedent's Name (First, Middle, Last) Certificate of Death	Reg.	No.
Physici	ian		2. Date of Death Month	Day Year 3. Time of Death
/Medie		Melvin Peter Yeshnik	April	14 2007 10.54 AM
Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death
	1 %	Carroll Hospital Center Westminste 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Carroll
⊬ Funeral Director		216-24-7693 12 M 2 F 77 Yrs. Months Days Hours Min.	(Month, Day, Ye	9. Birthplace (State or Foreign Country)
9		Usual Residence of Decedent	reb 23	1930 MD
irylan	_	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Ba-fa	Director	MD Carroll Westminster		1 ☐ Yes 2 🙀 No
ith th	Dire	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
death with the Maryland ma 23a or 28a-f show fribut be notified at	rai	1030 Oak Drive 21158		USA
er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spin feet) If Yes, specify Cuban, Mexican, Puerlo	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 1/2 136 17, or	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1947 − 1 □ Yes 2 □ No 1947 − 1 □ Yes 2 □ No Specify:		Sansitu
fethur 215-0036 hin 72 hours after an "naturat, or ite	ed	15 Decedent's Education 16a Decedent's Usual Conjunction	105	wiiice
215 215 215 215 215 215 215 215 215 215	Completed	(Specify only highest grade completed) (Give kind of work done during most of work)	ing	b. Kind of Business/Industry
21212 ad within giene. er then "	E O	Elementary/Secondary (0-12) College (1-4or 5+) Strationary Engineer 12 Welder/Pipe Fitter		Tarrasa Davida
nd nd all Hy	Bec	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Maid	Lever Bros den Sumame)
aryland 2121, should be filed within smarked other than "tumatic svent, the Mac	To I	Demetri Yeshnik Jennie	Martusz	zewski
FOR CONTROL MARKED THE STRONG THE		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura		
and and eatth		Denise Ann McDermott/Daughter4099 Della Drive	Westmin	ster.MD21157
Profit		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 04/18	3 2007 20c.	. Location - City or Town, State
timen tant:		4 □Donation 5 □Other (Specify) Loudon Park Cem	Ba	ltimore, MD
Baltimore, Maryland 21215-0036 Pentit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inpopriant: If them 27 is marked other than "naturer, or itema 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once.		21. Signature of Edheral Service Livensee Pritts Funeral H	Home and	Chapel, P.A.
40.200	\square	412 Washington F	Rd Westm	inster, MD21157
The state of		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory arrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)		Onset and Death
/Medical Examiner		Due to (or as a consequence of):	, ,	
1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	-	Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of):	dder	
rted	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
760, s be executed sicien and burial-transit	Exal	resulting in death) Last Due to (or as a consequence of):		
Box 68760, sath certificate be exattending physicien for use as the burial	cail	Chronic (ymphogytic le	enkemi	ia
68 tiffical ng phy as th				
Box 66	an/N	IF FEMALE: 23b. Was decedent pregnant on the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery
O. E. Be dea the att	sicia	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month Day Year
that the de detached is	Physician/Med	3 CHARIOWII		
IS, Free tha	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		to use contribute to the cause of death?
Cord w requir	Completed	Coyonit of activity accepted	1 🗋 Yes	2 No 3 Probably 4 Unknown
ec Blaw Blaw Bas b	npie	Serjare disir der.	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
al Re	Ö		performed?	? death?
f Vita vysician: vysician: is certific director,	E	25. Was case referred to medical examiner? 46. Place of Death Hospital:	(Check only one)	
Of Phys	. To	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Hom		6 ☐ Other (Specify)
on of ding Phy h. After thi funeral o	타	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work?	28d. Describe how in	jury occurred
Division of Vital Records, for Attending Physician: The law requires taler death. Director: After this certificate has been signe in by the funeral director, page 2 should be control to the funeral director.	fica	3 Suicide 6 Could not be 28e Place of Injury - At home farm street factors office	28f Location (Street	and Number or Rural Route Number,
Div spital or ours afte neral Dire	Certification;	4 Homicide determined building, etc. (Specify)	City or Town, Sta	ite)
d 0 0 =		29a. Certifier (Check only Check only 2 Medical Symming: On the basis of examination and/or investigation in multiplication in multiplica	and due to the cause	(s) and manner as stated.
To the Hos within 24 h To the Fur completely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	ed at the time, date a	ind place, and due to the cause(s)
To t com	Σ	29b. Signature and title of certifier 29c. License number	29d. D	Date signed (Month, Day, Year)
194		Annother 039502	Ĺ	1119107
TO TIVE		30 Name in address of person who completed luse of death (Item 23a) (Type, Print)	(0.1 1.	estiminter 40 21157
Stat		Syed S. Hosain MD 447, East hain sh 31. Dele filed (Month, Day, Year) 32. Dele filed (Month, Day, Year)	reet W	estminter in my
Registra		APR 1 6 2007		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 10, Day 2007 Year 10:34 A. M Lillian Zipkin 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery Suburban Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 13, 1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2□F 165-18-5453 87 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Maryland | Montgomery Rockville 10e. Street and Number 10f Zin Code 10g Citizen of What Country? 6111 Montrose Road # 627 20852 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. 1 Never Married 2 Married White 1 ☐ Yes 2 ☐ No Specify Specify 3 NVidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 4 Years Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abraham Furman Jenny (Unascertainable) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
447 Beloit Avenue, Kensington, California 94708 19a. Informant's Name/Relationship (Type. Print) Michael A. Zipkin - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 4/14/07 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the stath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myorcreha Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dia betes Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗗 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?1 □ Yes 2 ☒ No Was a. autopsy performed? 24a Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2/2 No 2€ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation Injury

Physician /Medical Examiner Examine The law requires that the death certificate be executed Box (

O.

Records,

Vital

Division or

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To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical

Physician

/Medical

Examiner

Director

Funeral

ģ

Completed

Funeral

Director

show

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medicones.

Physician/Medical <u>۾</u> Be Completed Certification: To

29a, Certifier

2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

APR

29d. Date signed (Month, Day, Year) April, 10,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

1

7

8600 Old Georgetown Rol. Tethesda MD 20814 Strauss Subrban Haspi MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature

and manner stated.

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Roger Lee Zepp 6:05 PM April /Medical 15 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 17, 19 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Months Country)
West Virginia Davs Hours 1 M 2 □ F 53 213-64-3527 Director 1953 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location show 10d. Inside City Limits r 28a-f show notified at Maryland Carroll Westminster 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or dical Examiner must be 21157 2333 Hampstead-Mexico Road Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examiner filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by Specify: 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Owner & Operator 3 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be Evan P. Zepp, Jr. Unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn K. Zepp, wife 2333 Hampstead-Mexico Road, Westminster, MD 21157 Baltimore, Pages 1 8 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1. ■ Burial 2 Cremation 3 Removal from State Evergreen Memorial 4/21/2007 Finksburg, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home islan 91 Willis Street, Westminster, MD 21157 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER UNG METASTADO /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of death certificate be executed physician and the burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) P.O. the 9 Unknown as been signed by 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy page 1□ Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 0 Ro ဥ 1 TYes 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral dir 28a. Date of Injury Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 12 Natural 2 Accident (Month, Day Year) To the Husping after death, within 24 hours after death.

To the Funeral Director: Aft 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 5 29d. Date signed (Month, Day, Year) 027730 WIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 BAIT/ MORE, 40 21204 6569 MU CUARLES N. COLLEN

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month. Day, Year)

ORIGINAL

32. Regitrar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Eleanor M. Aldridge 2007 3:30 A. M Apri1 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 216 05 2709 92 Director May 20, 1914 Maryland Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eaith and Mental Hygiene.
n 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director Maryland Anne Arundel Gambrills 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1344 Defense Highway 21054 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Be Completed by 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner Restaurant 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Lorenz ဥ Tillie Augustiniak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Rea Aldridge 1765 Baldwin Drive Millersville, Maryland 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Our Lady of the Fields 4/30/2007 Millersville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Juneral Service Lice 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (o as a consequence of): Examiner neumania Sequentially list conditions, if any, leading to immediate cause. Energy in carrying Cause (Disease or injury that initiated events resulting in death) Last Examiner Du to (or as a consequence of) The law requires that the death certificate be executed paneventitis acure and as the burial-tra Due to (or as a consequence of): has been signed by the attending physician ge 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 9□Unknown Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perfor After this certificate 1∐ Yes or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 20 No 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Division or Vital Records, P.O. Box 68760 within 24 hours after death To the Funeral Director:

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

anne

DHMH 17 Rev 1/2001

LIVAN 32 Registrar's Signature

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

2007

MD

ORIGINAL

29c. License number

D62242

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician BROWN 0827 M Konald /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimor niversit OV If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min 5. Social Security Number dge (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Ctuber 27, 1969 213-90-1621 M 2□ F Director MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BURNIE 1 ☐ Yes 2 No Directo YARYLAND DUNT 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? USA 14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 HTGRADE NATIONAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ FRED 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition Date 1 🛎 Burial 2☐Cremation 3☐Removal from State permit. Page Department o Important: If any Injury or once. UMCCEMETERY 05-05-07 PASADENA. 4 ☐ Donation 5 ☐ Other (Specify) of Funer Service Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Celvala disease or condition resulting in death) /Medical Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of) Physician/Medical Examiner Division or Vital Records, P.O. Box 68760, been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed cate has been s , page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform es 2 To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No filled in by the funeral director, Medical Certification: To Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Nnpatient 27. Manner of Death Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Natural 5 ☐ Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 29b. Signature and little of certifier 29c, License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

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13	0	13	47		1.	1	7
	2	20	200	2007	2007 1	2007 14	2007 160

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

n	Anthony Joseph Belzner	Sr.				Month April	29,	^y 200 ^{Year}	8:40a	М
al er	4a. Facility Name (If not institution, give street and number			4b. City, Town, or	Location of Dea			. County of Death		
N. Sec.	Eastpoint Nursing Home	2		Balti	more			Baltim	ore	
		ge (In yrs. last b	oirthday)_	If Under 1 Year Months Days	If Under 24 Hr		th v. Year	9. Birth	nplace (State or For	reign
	220-22-3301 XIM 2 F	78	Yrs.	Days	Tiodio itiii	2-2-1			timore	
	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Loc	ation					10d. Inside City Lir	mite
'n	MD	Balti							1 ▼Yes 2	
ecto	10e. Street and Number	Daici	. IIIOI (10f. Zip Code			10a Ci	tizen of What Cou		
ä	3612 Roberts Place			212	24		US		andy:	
Funeral Director	11. Marital Status 12. Was Deceden	t Ever in U.S.	13. W			Specify Yes or No		14. Race - Amer	rican Indian,	
ᇤ	Armed Forces 1 □ Never Married 2 ☑ Married 1 ☒ Yes 2 □	? No Mari	ne			Specify Yes or No rto Rican, etc.)		Black, White	_	
۾	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates		1	□Yes 2∏XNo	Specify:			Specify: Wh	ite	
Be Completed	15. Decedent's Education (Specify only highest grade completed)	16	a. Decede	ent's Usual Occup	ation	orkina	16b. K	(ind of Business/I	ndustry	
ple be	Elementary/Secondary (0-12) College (1-4or	r 5+)		ind of work done O NOT use retired		Jikilig	D.	4 h l 4 h 4-	- Chaal	
ပ္ပ	8th		Stee	elworke				thleher	" Steel	
Be	17. Father's Name (First, Middle, Last)					me (First, Middle	, Maidei	n Surname)		
ပ	Anthony Belzner					rnadine				
	19a. Informant's Name/Relationship (Type. Print) wif					Rural Route Numb Baltimo				
	Josephine Belzner 20a. Method of Disposition					Date		ocation - City or		
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	e Come	tery, crem	ition (Name of atory or other place Heart o	(e) (f) 5/2			Ltimore		
	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service (Scene)	Saci	eu i	Name and Addre	ss of Facility T	oseph N			•	
	Mal Varia					g St.Ba				
	23a. Part1. Enter the disease, or complications that cause shock, or heart failure List only one cause on each	ed the death. Do	1						Approximate	
	shock, or heart failther List only one cause on each Immediate Cause (Final	T. L.		1. 2	lant	Dear			Interval Between Onset and Deat	n h
	disease or condition aa.	is a sonsequence	OSC e of):	eroal (reau	viease				
	546 18 (8)	athan	1260	Oo Mari		Disease				
Jer		s a consequence	e of):	000 0000						
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
Ě	resulting in death) Last Due to (or a	s a consequence	e of):							
an/Medical	d						7			
Mec	IF FEMALE:									
		2 Fetal dea		Ectopic pregnancy	/			23d. Date of deli Month	ivery Day Year	
ysici	1 ☐ Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown 9 ☐ Unknown	at time of death	5∐	Other (specify) _						
Completed by Physi	Part II. Other significant conditions contributing to death	but not resulting	in the un	derlying cause giv	en in Part I.	23e. Did 1	tobacco	use contribute to	the cause of death	n?
d b	atrial fabrillation					1 🗆	Yes 2	P. No 3 □ Pro	obably 4 Unkn	nown
ete	Coronaus astern	Diseas	_			24a. Was	an	24h. Were au	topsy findings avail	lable
щ	Tun 2 Dichet -	ma 00.	Eur			auto perfe	psy ormed?	prior to death?	completion of cause	e of
	25. Was case referred to medical	rizco	1000		26. Place of D	1 Yes eath (Check only o	2 N	o 1 ☐ Yes	2 No	
o Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpa	tient 2 ☐ ER/0	Dutpatient	3 DOA Oth				6 □Other (Spec	city)	
л: Т	27. Manner of Death 28a. Date of In		. Time of Injury	28c. Injur Wor		28d. Describe			27	
atio	2 Accident investigation	, ay , sa.,	,,		Yes 2 □ No					
tilic	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of in building,	njury - At home, etc. (Specify)	farm, stre	et, factory, office		28f. Location (City or To	Street a wn, Stat	nd Number or Ru e)	ıral Route Number,	
Medical Certification: To										
Ca	29a. Certifier (Check only (Check only 2 ☐ Medical Examiner: On the basis	of examination								
Med	one) and manner: 29b. Signature and title of titler	stated.		29c. Licens	e number		29d D	ate signed (Montl	h Day Yearl	
	her h	_			211150			1		
		d	\ (T					101/20		
	30. Name and address of person who completed cause of MELITO M. TORRES, V	death (Item 23a	1) (Type, F	FILUS	ood AUR	BALTO	1	10 01:	224	
e	31. Date filed (Month, Day, Year) 32. Regis	strar's Signature				1				
ar	MAY 0 2 2007 Reserve	D. A	pert	A. C.						

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 7

State Amend 10e, 19b, perFH, g867, 5/2/07 TT

Certificate of Death 14050 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day Year 6.45 AM Clarence Edward Brunt Sr. 28 /Medical 2007 4a. Facilify Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner hospital Baltimore omai Baltimore If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Days **X**□M 2□F Director 78 217-24-6746 28 06 MD Usual Residence of Decedent uld be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Boarman Funeral 21215 Bowman Ave U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1**X**]Yes 2 □ No If Yes, Give Year or Dates; 1 ☐ Never Married 2 X Married 21215-0036 1 ☐ Yes 🎾 No Specify: Black \$ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 2yrs Mechanic Factory nt of Health and Mental Hygir: If item 27 is marked other or other traumatic event. It Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Brunt Annie Bell Charity 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Boarman Bowman Ave, Baltimore, Md
tion (Name of Date 20c. Location 2901 Valetta Brunt 21207 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ott once, Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 5/4/07 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. lart1. Enter to disease, or complication at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic obstructive pulmonary disease Exacertation 3 days /Medical Due to (or as a consequence of): **Examiner** Such mielly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ mellitus certificate has been si rector, page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Chronic Renal 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 No the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 April 28 2007 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore, 2401 w Belvedere ave Baltimore mp 21215 w Belvedercave ARUNA ROKKAM MP 31. Date filed (Month, Day, Year) 32. Resstrar's Signature State Registrar

DHMH 17 Rev 1/2001

CLARGNCE

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ohn icharc Da 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Sex I 1 M 2□F Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Min. Hours 3 Havre de Graco MI 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Hai 10e. Street and Number 10g. Citizen of What Country? 21047 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hallston Kitchen 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 10 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) therine 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Forest Hill MD 21050 ROLA 1 Chapel+ Cremation Service 23a. Parl I. Enter the disclase, or or a licetions that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only one cause on each line. Immediate Cause (Final TETASTATIC NON SMALL CELL disease or condition resulting in death) 4 months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day Other (specify) rlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔀 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ▼No autonsy e of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ¶Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA te of Injury onth, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

/Medical Examiner Examiner The law requires that the death certificate be executed signed by the attending physician Medical Certification: To Be Completed by Physician/Medical

Physician

/Medical

Examiner

10a. State

Funeral Director

Be Completed by

2

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Maryland 21215-0036

29/07 Baltimore,

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8669

0

Box 68760,

Division or Vital Records.

Bem, John

ortant; If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at

Department of Health and Mental I Important: If Item 27 is marked of any Injury or other traumatic even once.

Physician

tal Hygiene.

within 24 hours after death.

To the Funeral Director: /
completely filled in by the f

25.

1 □ Yes 2 □ No 9 □ Unknown	9□Unknown	300
art II. Other significant condition	ons contributing to death but not resulting in	the unde
		

Was case referred to medical examiner?		26, Place
examiner/		

1 ☐ Yes 2 🔼 N	lo	1 10Spital.
27. Manner of Death 1 Natural 2 Accident	5 ☐ Pending investigation	28a. Da (M
	C Could not be	

1 Yes 2 No

☐ Suicide	☐ Suicide ☐ Homicide	6 Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
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28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)	2 Medical Ex
29h Signature/land	d title of dertifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

S. Seursailam	MI
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DA5530

4-29-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

	5.	5	10	A	SA	ILA			SUI		
31	. Date f	iled (Month	, Day	, Year)		3	Reg	istrar's S	ignatur	e

602 SATWOOD, BELAIR, MD 21014 200,

15 State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav WILLIAM DEMBY BAILEY /Medical April 2007 6:00 26 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE
If Under 1 Year | If Under 24 Hrs. 2206 LUKEWOOD DRIVE N/A Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Min. 1**XX**M 2□ F Hours 89 Director 220-03-3732 NOV. 20 1917 MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be matriced. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1XXYes 2 ☐ No Directo BALTIMORE MARYLAND N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2206 LUKEWOOD DRIVE 21207 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1XXYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married ŽXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXVo Specify 2 Specify: BLACK 3 Widowed 4 Divorced 41/45 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DEPT OF NAVY 12th grade LABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ೭ HERMAN BAILEY CARRIE BAILEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Maureen Bailey/Wife</u> 2206 Lukewood Dr., Baltimore, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SPRINGHILL MEM GRDN 05-03-07 HEBRON, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Verluga cour 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Physician 24esis /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☑ No 3 Probably 4 ☐Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy page performed? Yes Kan death? 1 ☐ Yes 2 ☐ No certificate 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number

144

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAY 02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

75050561

32. Begistrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

016587

1owson,

430Z,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	= For State Amend #1 Registrar	.9b, perl	FH, G867, 5/			rtificate of	Death		F	Reg. No.	4 U U /		G U &	J
Н	Physicia		1. Decedent's Name (Firs								Date of Dea Month	Day	Year		ne of Death	A
	/Medic	al .	Betty Louise					4b. City, Town,			1pril	25	ounty of Deatl		:40 PM	
	Examin	er	4a. Facility Name (If not in Union Memoria		_			Baltimore	9			N/A	١			
	Funeral Director		5. Social Security Numbe 171–28–7182	1	ex	ge (In yrs. la 71	ast birthday) Yrs.	If Under 1 Year Months Days	if Under 2 Hours	Min. 8. [Date of Birth Month, Day 05/10/1	, Year) 1935	9. Birth Con Penn	nplace (Stantry) Sylvan	iate or Foreig	'n
	and w	-	Usual Residence of Dece 10a. State 10b.	County		10c. City	, Town or Lo	ocation						10d. Insid	le City Limits	s
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	th the	Funeral Director	10e. Street and Number					10f. Zip Code					en of What Co	untry?		
	ath wi	ral	700 W. 40th S	treet			2 40	21211	U''- O-'	-1-0 (016)	Van au Na	U.S.A	4. Race - Ame	rican India	n	
	items	une	 Marital Status Never Married 2 	2□ Married	12. Was Decedent Armed Forces 1 ☐ Yes 2 🔀	?	5. 13.	Was Decedent of If Yes, specify Cub	ban, Mexican	n, Puerto Rica	in, etc.)		Black, White		,	
36	urs aff	þ	3 ⊠ Widowed 4 □		If Yes, Give Year or Dates:			1 □ Yes 2 💢 No	Specify:			5	Specify: W	hite		
15-0036	be filed within 72 hours after death with the Maryland at Hygiene. do other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. I (Specify on	Decedent's Ed	ducation ade completed)		16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most	t of working	Ī	16b. Kind	d of Business/	Industry		
121	within ane.	mpl	Elementary/Secondary	(0-12)	College (1-4or	5+)		Maker	9d)			Own	Home			
Maryland 2121	filed v Hygie other t		17. Father's Name (First,	Middle, Last,)		TUIL	rigiter	18. Mothe	er's Name <i>(Fi</i>	rst, Middle,					
lan		To Be	Paul Shepherd						Sarah	Popper						
a _Z	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		19a. Informant's Name/F		Type. Print)		1	ng Address (Stree				er, City or	Town, State, 2	Zip Code)		
∑ ⊘	and and marken the structure to the stru			.1, Son		20h P		Box 1806 M		llinois Date		20c Loc	ation - City or	Town Sta	te	
٥	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cre	emation 3		3 I		osition (Name of matory or other pla Redeemer		05/01/2			more, Ma			
Baltimore,			4 □ Donation 5 □ 21. Signature of Funeral			Irust		2. Name and Addr			nard J.				•	
ñ	permit. Departr Importa any Inj	0.7	algoandri	Bose	tes			305 Harfor		altimore	e, MD 2	1214				
Н	*		23a. Part1. Enter the dis shock, or heart fail	sease, or com ure. List only	plications that cause one cause on each	ed the death line.	. Do not en	ter the mode of dy	ring, such as	cardiac or re	spiratory ar	rrest,		Interva	kimate al Between and Death,	
	Physician		Immediate Cause (Final disease or condition resulting in death)		a. Arr	hyt	hm1.								week	
	/Medical Examiner		resolding in deadily		Due to (or a			Hoart	Ea	1/11/0				5	VOALS	_
-4	Sing and	er	Sequentially list condition any, leading to immediate	ns,	b. Due to (or a	a consequ	uence of):	110111	1 / 3 /	,,,,,					YEANS YEANS	
	cuted nd ransit	Examiner	Sequentially list condition any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events	1	c	CONA	ry	Heart	10	1 SEAS	ŝe_			10	Years	<u>`</u>
90	oe exe cian a	E EX	resulting in death) Last		Due to (or a	s a consequ	uence of):		,							
68760,	rificate be executed by physician and as the burial-transit	ledical			_ d											
	n certif		iF FEMALE: 23b. Was decedent preg	gnant	23c. If yes, outcom			□Ectopic pregnan	new .			23	3d. Date of de			
Vital Records, P.O. Box	w requires that the death cer been signed by the attendin should be detached for use	Physician/N	in the past 12 mon 1 ☐ Yes 2 ☑ No	ths?	4□Pregnant 9□Unknown			Other (specify)	icy				Month	Day	Year	
<u>Р</u>	hat the d by tl letach	Phy	9 ☐ Unknown Part il. Other significan	t conditions	contributing to death	but not resi	ulting in the I	underlying cause of	iven in Part I	ı.	23e. Did t	obacco us	se contribute to	o the caus	e of death?	
ds,	uires ti signe id be c	Completed by	Clostrid		Dificil	1	2 /				1 🗆 1	Yes 2□	No 3□P	robably	4 🖪 Unknov	vn
Ö	w req	lete	HYPERT	ten su	~~					1	24a. Was		24b. Were a prior to death?	utopsy find	lings availab)le
8	sician: The law certificate has be irector, page 2 s	omp	DiAbe	4								ormed?	death?	completion 2 □ No	o cause o	
ita	stan: ertifica ctor, p	BeC	25. Was case referred to examiner?							e of Death C	heck onl	one				
<u>7</u>	hysic this ce al dire	은	1 ☐ Yes 2 ☐ No				ER/Outpatie	,,,, o D D O / ()			5 ☐ Resi		Other (Spe	ecify)		
Division or	ding Phys	ion:		☐ Pending investigation	28a. Date of Ir (Month, I	Day Year)	Injury	W	ork? □ Yes 2 □		i. Describe	now injury	occurred			
/isi	Atten	fical	2 ☐ Accident 3 ☐ Suicide 6 4 ☐ Homicide	Could not b		njury - At ho	ome, farm, s	l treet, factory, offic	e	28f.	Location (Street and	d Number or R	ural Route	Number,	
ă	s after s after al Dir	Certification:														
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier 1 ☐ (Check only one)	Certifying P Medical Exa	hysician: To the bearing the basis and manner	of examina	wiedge, dea ition and/or i	th occurred at the investigation, in m	time, date ar y opinion, de	ath occurred	d due to the at the time,	cause(s) , date and	and manner a place, and du	s stated. e to the ca	ause(s)	
	To the within 2 To the comple	Med	29b. Signature and title	of certifier	and manner	stateu.		29c. Lice	nse number			29d. Date	e signed (Mon	th, Day, Ye	ear)	
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7	b		30. Name and address	of person who	completed cause o	death (Iten	n 23a) (Type	, Print) 🗸	5NN11	Fox 1	Nozi	0175	r11 2:			
			31. Date filed (Month, D		em57/17	strar's Signa	OS Pij	tra /	BAIT	mor	e, n	no				
A)	Sta Regist		M	-	2007	ELAG.	J. A	to l								
			111	A A A I.M.		~										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** APRIL THOMAS CODD NILLIAM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WESTMINSIE.

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 14N 6 1928 CARROLL CARROLL HOSPICE DOVE HOUSE 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 219 22 5918 Director MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 No **Funeral Director** CARROLL WESTMINSTER MO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ò WEST LIBERTY ROCK 21157 23a SA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 2 No 1944-1 Never Married 2 Married 1 XYes 2 ☐ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 📉 No þ 3 Widowed 4 □ Divorced 1948 WHITE "natural" Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE Gas & item 27 Is marked other than other traumatic event the No. Elementary/Secondary (0-12) College (1-4or 5+) NEMAN FLECTRIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HAFFER WILLIAM T. CODD, SR MARGERUITE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2417 West Liberty Road Westminster, MD 21157 ALLEN CODD 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If itel any Injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State EST LAWN Mem. 5/4/2007 WEST FRIENDS, +, P. MO Donation 5 Other (Specify) 22. Name and Address of Facility IN ZUM BRUN FH & MON. Co 21. Signature of Funeral Service Licensee ELDERSBURG MD 21784 6028 SYKOVILLE ROOW Enter the disease e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 2 Mcurfus Immediate Cause (Final disease or condition resulting in death) **Physician** MEDIASTINITIS /Medical Due to (or as a consequence of): Examiner SOFHAGEAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ HO 24a. Was an autopsy performed 2 40 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) INPATIENT Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Mother (Specify) မှ 1 ☐ Yes 2 NO 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 5 Pending investigation 1 Matural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

y,

State Registrar 31. Date filed (Month, Day, Year)

NAY 0 2 2007

2. Registrar's Signature

1000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland / De	ertificate d				201	17	14055
			Registrar 1. Decedent's Name (First, Middle, L	anti			Dealli		2. Date of De	Reg. No.		3. Time of Death
	Physici	an		Cleary					Month	28 2007	Year	
	/Medic	al	Rita Barbara 4a. Facility Name (If not institution, gr			4h City Town	n, or Location	of Death	Abrit	4c. County	of Death	1:20 AM
	Examin	er	Manor Care Rux				nore Co			Balt		<u> </u>
	F				e (In yrs. last birthda	y) If Under 1 Ye	ar If Under	24 Hrs.	8. Date of Bir		9. Birthp	place (State or Foreign
Н	Funeral Director			1 M 2 XF 91		Months Da	ys Hours	Min.	8. Date of Bir (Month, Da May 14	^{y, Year)} 1915	Cour	imore,MD
	υ		Usual Residence of Decedent		1							
	rylan show	_	10a. State 10b. County		10c. City, Town or						1	10d. Inside City Limits
	Be-f s	cto	Maryland Baltim	ore	Baltimor	re County						1 Tyes 2 No
	or 20	Dire	10e. Street and Number	unt Ant A		10f. Zip Cod 21234				10g. Citizen of V USA	Vhat Cour	ntry?
	filed within 72 hours after death with the Maryland Hygiene. sthar than "natural", or Itams 23a or 28e-f show ent, Ita Medical Eractinet mant be notified at	Completed by Funeral Director	2803 Upridge Co	<u> </u>	5				if - Man as his		o Amorio	can Indian,
	er de Itam	n.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent I Armed Forces?	Everin U.S.	 Was Decedent of If Yes, specify C 	or Hispanic Or Cuban, Mexicai	n, Puerto	Rican, etc.)	Blac	k, White,	
36	rs aft	by F	3 ₩ Widowed 4 Divorced	1 ☐ Yes 🎗 🔯 N If Yes, Give Year or Dates:	10	1 ☐ Yes 2 💢	No Specify:	:		Specify	" Wh	nite
Ö	2 hou	ted	15. Decedent's I	Education	16a. De	cedent's Usual Oc	cupation			16b. Kind of Bu		
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7	ad wit	Sorr	12	N/A		emaker						ng⊷Own Home
p	oe file al Hy H oth	Be (17. Father's Name (First, Middle, Las	st)						Maiden Sumam	18)	
yla	should be and Mental marked o	²	George Smith						e Neusc		_	
Maryland 21215-0036	S Pull		19a. Informant's Name/Relationship			ailing Address (Str				7		
6, 7	1 and Health Sm 27 ther t		William J Clear 20a. Method of Disposition	у		L30 Towns			Date	20c. Location -		
Baltimore,	ages or or o		1 XBurial 2 Cremation 3		cemetery, c	rematory or other	place)					
뜶	it. Partime		' 4 □ Donation 5 □ Other (Spec		MOST HOT	y Redeemer				Baltimor	e, mary	/Land
Ba	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tre ance.		The least)		22. Name and Ad Lassahn	Funera	1 Ho	me Inc			04000
			23a. Part1. Enter the disease, of co shock, or heart failure. List only	mplications that caused	the death. Do not	7401 Bell enter the mode of	Latr HO dying, such as	ad B	altimor or respiratory a	e, Mary rrest,	Land	21236 Approximate Interval Between
	Physician		mmediate Cause (Final	ly one cause on each in	FRPD	i/Acri	-	0				Onset and Death
	/Medical		disease or condition resulting in death)	30000			11-4	1	1410	11/1/12/	3519	•
			A Cooking in sound,	Due to (or as	a consequence of):		1641	RI	MR	019130	95/3	7
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68760, y	le be executed ysician and le burial-transit	icai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):	ROKE	C			11230	95/3	Drys.
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Physicia		1- For State Registrar 1. Decedent's Name (First, Midd	ile.Last)	Cer	tificate of	Death		2. Date of De	Reg. No.	3. Time of Death	
Medical Exami	ner	Kent Julian	Crawfor	d II				Month April 22,	Day Yea		
6		4a. Facility Name (if not institute South of Beaver Dam	on, give street and r	number)	4	b. City, Town, or Lo Beltsville	ocation of Death		4c. County of		
Funeral		Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of E		9. Birthplace (State or	
Director		577-08-6918	1X M 2 F	38	Yrs.	Months Days	Hours Min.	07/08	/1968	Foreign Count DC	
,		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Location	20			7	10d. Inside City Limits	
d how any			e Georg	1	stvill					1 X Yes 2 No	
Aarylan 28a-f s	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	nat Country?	
ith the Maryland 23a or 28a-f show notified at once.		6954 Blue Ho				20747			USA	<u>.</u>	
eath wi	Funeral	11. Marital Status 1 X Never Married 2 M	Married Armed	ecedent Ever in U. Forces?		s Decedent of Hispa es, specify Cuban,				- American Indian, Black, e, etc.	
after d	by Fu	3 Widowed 4 Dir	vorced If Yes, Give Yor Dates:	2 X No	1	Yes 2 No	specify:	attin and one	Specify:	Black	
hours "natur	ted	15. Decedent's Education (Spe Elementary/Secondary (0-12)	ecify only highest gr	ade completed) (1-4 or 5+)		's Usual Occupationst of working life. I			16b. Kind of Bu	siness/Industry	
036 thin 72 ne.	Completed	9th	College	(1-4-01-5+)	Invest	cor			Self E	mployed	
215-0036 be filed within 7 ntal Hygiene. 'ked other than ent, the Medica		17. Father's Name (First, Middle							, Maiden Surname	•	
212' uld be Mental marke	To Be	Kent Julian 19a. Informant's Name/Relations		a	19b. Mailing		_		Wingfie	m, State, Zip Code)	
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	٦j	Kent Crawfor	d/Fathe							le MD 20747	
Ore, ges lan of Hea If iter		20a. Method of Disposition 1 X Bunal 2 Crematio	n 3 Removal	from State	crematory or oth			Date		- City or Town, State	
Baltimore, permit. Pages I ar Department of Hee Important: If ite	- 7	4 Donation 5 Other S 21. Signature of Funeral Service		Res		tion Cer ame and Address o			Clinto	N	
Ba Depermining	Щ	Jer Jer	net C.	desem		WN 45		35	ads S	HNE 20019	
Physician /Medical		23a. Part I. Enter the risurse, or failure. List only an a cause		caused the death.	. Do not enter th	e mode of dying, s	uch as cardiac or	respiratory a	rrest, shock, or he	Between Onset and	
xaminer		Immediate Cause (Final disease or condition resulting in death)		njuries a consequence of	f):					Death	
		Sequentially list conditions,	b								
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		a consequence of	f):						
nd ransit	Examiner	events resulting in death) Last	,	a consequence of	f):						
e execut yian and rial - tran	= 1	UNPENDED	d AMENDED)							
ox 68760, aath certificate be ex attending physician for use as the burial -	Physiclan/Medica	IF FEMALE: 23b. Was decedent pregnant in t	ho	, outcome of pregr					23d. Date of		
Box 68760, e death certificate b the attending physical for use as the but	iclan	past 12 months?	4 Pres	birth gnant at time of de	ath	al death 3 ner (Specify)	Ectopic pregnar	ncy	Month	Day Year	
. Bo. he deat	hys	1 Yes 2 No 9 Un Part II. Other significant condi		nown			i- D-d l	220 Did	tobogo uso contr	ibute to the cause of death?	
Division of Vital Records, P.O. B. ral or Attending Physician: The law requires that the de irs after death. Al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be deached if	ā	Part II. Other Significant condi	itions contributing	to death but not re	esulling in the u	ndenying cause giv	en in Part I.		es 2 V No 3		
cords, law requir has been si	Completed	-,-,-						24a. Wa		Were autopsy findings available prior to completion of cause of	
Reco The law icate has	E S					·		per	formed?	death? Yes 2 No	
Vital Reorgician: The his certificate director, page	a B	25. Was case referred to medica examiner?	Hospital:				of Death (Check of				
n of Vit ding Physic 1. After this	입	1 Yes 2 No 27. Manner of Death	28a, Dat	Inpatient 2	ER/Outpatient 28b. Time of Ir			Home 5 28d, Describ	Residence 6 e how injury occurr		
On C tending sath. or: Af	tion		iding Apr 22	th, Dav Ýsár) , 2007	0532 hrs				uto involved ir		
ivisi lor Att after de Direct	Certification:	3 Suicide 6 Cou	lid not be			t, factory, office bui	lding, etc.	28f. Location or Town,	(Street and Numb State)	er or Rural Route Number, City hington Parkway , Beltsville,	
D lospital I hours uneral	<u>5</u>	29a. Certifier		/ Interstate/E		rod at the time, date					
Division of Vital Records, P.O. Box 68760, To the Hospital and Attending Physician: The law requires that the death certificate be execution; after death. To the Funeral Director: After this certificate has been signed by the attending physician at completely filled in by the funeral director, page 2 should be detached for use as the burial -	Medical	(Check only	Physician: To the be aminer:On the basis and manner	of examination at							
E % E 8	₩	29b. Signature and title of certific		////		29c. License				ed (Month, Day, Year)	
		4	NVI.	t		O.C.M	.E.		April 22, 20	J07	
\		30. Name and address of the sor Jack Titus MD. De	n who completed at puty Chief Med	•	•	n Street, Baltir	more, MD 21	201		-	
		31. Date filed (Month, Day, Year)	TV.	Registrar's Signatu	ire Angele	9					
Regist	rar	MAY 0 2 2	71111/ Alle	URS ST.	19						

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	State of Maryland / Department of Health and Mental Hygiene	

		- For State			Certific	cate of	Death				R	eg. No			
Physicia		Decedent's Name (First, Midd	le,Last)							2	. Date of Dea Month	th Day	Year	3	3. Time of Death
∜ical Examin		James R	ona1d	Correy	7						April 25, 2	2007	Tour	_ '	2050 hrs
		4a. Facility Name (if not institution	on, give street a			41	c. City, Tow	m, or Lo	cation of I	Death			c. County of I		
	П	2294 Blue Water Blv	d.				Odento	n,MD					Anne Arur	ndel	
Funeral	T	5. Social Security Number	6. Sex	7. Age	(In yrs. last bi	rthday)	If Under 1		If Under 2		8. Date of Bi	rth(MN	I/DD/YYYY)	9. Birth	place (State or
Director		240-33-0621	1 X M 2	F	40	Yrs.	Months	Days	Hours	Min.	March	12	.1967	Cour	North Carolina
	-	Usual Residence of Decedent	41		70					اا			<u> </u>		
any		10a. State 10b. County		Ī	10c. City, Town	n or Locatio	n							- 1	10d. Inside City Limits
3		Maryland Anno	Arunde	1		Ode	nton								1 XYes 2 No
Maryland 28a-f show d at once.	황	Maryland Anne	Arunue	<u> </u>		- 000	10f. Zip Co	ode				10g. Ci	tizen of Wha	Count	ry?
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director							011	1.0			TT	nited	C+a	tod
th th 23a notif		2024 Pine Cro		s Decedent	Everin II C	13 14/20		211		12 / Sne	cify Yes or N				an Indian, Black,
th wi	Funeral	11. Marital Status 1 Never Married 2 X N	larned Arn	ned Forces?	Ever in U.S.		s, specify (,	White,		
or it	ᇍ		1 A		No		V-0 0 37	No	onocifu.		,		Specify:	7.7	hite
s afte	2		vorced If Yes, Gi		mistod) 16 s	. Decedent	Yes 2 X			nd of wo	rk done	16b	Kind of Busi		
hour nath Exan	P P	15. Decedent's Education (Sp	· · ·				st of working					- 1	United		
n 72	ompleted	Elementary/Secondary (0-12	Coll	ege (1-4 or 5	0+)	0							Air Fo		
5-0036 led within 7 Hygiene. other than the Medica	틹	47 F. 0 - 1 M - (P' 1434)	1 004)	5+		C	aptai	.n	Mother's	Name /	First, Middle,			rce	
Hyg d off	ပ၂	17. Father's Name (First, Middle	_					- 1 "		Rita	Eri				
2121 Muld be fi Mental marked c event,	8 B	Arthur J. 19a. Informant's Name/Relation	Corr		11	Oh Mailing	Address	(Street	_				City or Town,	State.	Zip Code)
D 2 shoul and N is m	\vdash														d 21113
MD and 2 sho salth and 2 sho salth and raunatis	ŀ	Marie M. Corr	ey/wife			ZUZ4 e of Disposi					Date	200	Location - 0	City or 1	own, State
S 1 a of He lite		1 Burial 2 XCrematic	n 3 Rem	oval from Sta	ate crem	atory or oth	er place)								
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Jani: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		4 Donation 5 Other 5	Specify:		West	Arund									Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	Ī	21. Signature of Funeral Service	e Licensee			22. N Do	ame and A nalds	ddress (SON	of Facility Funer	cal :	Home &	Cr	emator	у,	P.A.
m 80 E E		4/5	4r			1141	1 Ann	apo	lis F	Road	Oden	ton	, Mary	'Lan	d 21113 Approximate Interval
Physician		23a. Part I. Enter the disease, of failure. List only one caus	r complications e on each line.	that caused	the death. Do	not enter tr	ne mode of	dying, s	uch as cai	rdiac or	respiratory a	rest, s	nock, or near	ı	Between Onset and
'Medical kaminer		Immediate Cause (Final diseas	e a. ntraoi	al shotgu	n wound							_			Death
Zummer		or condition resulting in death)	Due to (or as a conse	equence of):										
	_	Sequentially list conditions,	b. Due to /	or as a cons	equence of):			-			_	_	·		
	Ψį	if any, leading to immediate cause. Enter Underlying Caus		DI 43 4 00110	oquonido ory.										
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and trans			d									_			_
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68760, certificate be nding physic se as the bur	/Me	IF FEMALE: 23b. Was decedent pregnant in		If yes, outcor Live birth	me of pregnand		tal death	2	Ectopic	prognar	acv.	1	23d. Date of o Month		ay Year
Sox 687 leath certifing e attending for use as t	Physician	past 12 months?	4		time of death		tai deatri her (Specii		ctopic	progridi	icy		THO COLOR	_	
Box e death c the atten	ysic	1 Yes 2 No 9 U	nknown g	Unknown		3 01	ner (Specii								
O. Be nat the dered by the setached for	Ph	Part II. Other significant cond	itions contrib	uting to deat	h but not resul	ting in the u	ınderlying o	cause gi	ven in Par	rt I.	23e. Did	tobacc	co use contrib	oute to t	the cause of death?
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aw re has be 2 she	βę											opsy form <u>ed</u>		nor to c eath?	ompletion of cause of
Rec The cate	Completed										1 Yes	2	No 1	√ Ye	s 2 No
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Vit hysic	To	1 ✔ Yes 2 No	Hospital:	i iipati		/Outpatient		//\			Home 5		idence 6 🗸		Scene
ing Pl		27. Manner of Death	I	a. Date of Inju (Month, Day) or 25, 2007		b. Time of I 000 hrs	njury 28		y at Work?	!!	Subject sh		injury occurre e if	eu .	
tend eath. tor:	atio		nding restigation	JI 25, 2007	00			1Y	es 2 🗸						
Division tal or Attendi rs after death. 'at Director: /	ific	3 ✓ Suicide 6 Co	uld not be 28	e. Place of Ir	njury - At home	e, farm, stre	et, factory,	office bi	uilding, etc	- 1	or Town	State)	r or Ru	ral Route Number, City
Divis	Certification:	4 Homicide		pecify) W			<u>-</u> -						Blvd., , Md.		
Hos 24 h Fun etely	ä	(one on any	Physician: To	the best of m	ny knowledge,	death occur	rred at the t	time, da	te and pla	ice, and	due to the ca	use(s)	and manner	as state	ed.
To the within To the compl	edical			basis of exa anner state		or investiga				curred a	une ume, da				
[, []	ž	29b. Signature and title of cert	fier	/					number			- 1			nth, Day, Year)
X		1a/2-111	100		16			O.C.1	Λ.E.			A	pril 26, 20	U /	
1		30. Name and address of pers	on who complet	ed cause of	death (Hom 23	a)									
X,		Zabiullah Ali, M.D.	Assistant l	Medical E	xaminer	111 Per	n Street	, Balti	more, N	MD 212	201				
	tate		r)	2. Registra	ar's Signature	1.	9.								
Regis	trar	MAY 0.2	2007	Marge 15	St.	GORAL									
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2007 14058

	For State Ce	ertificate of Death	Reg_No	
Physician/	egistrar . Decedent's Name (First, Middle,Last) SHERRI LEE CLUGSTON		2. Date of Death Month Day April 29, 2007	3. Time of Death Year 1711 hrs
Medical Examiner	ia. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De	ath 4	c. County of Death
/	Holy Cross Hospital	Silver Spring		Montgomery
Funeral Director	5. Social Security Number 215-02-7804 6. Sex 1. Mm 2 xF 38	. last birthday) If Under 1 Year If Under 24t Months Days Hours M Yrs.	Hrs. 8. Date of Birth (MN Win. Oct. 4,	MDD/YYYYY) 9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent	ty, Town or Location	- 1	10d. Inside City Limits
, 1		lver Spring		1 Yes 2 XXNo
tor 28a-f show	10e. Street and Number	10f. Zip Code		itizen of What Country?
13a or notifie	2330 Briggs Chaney Road 11. Marital Status 12. Was Decedent Ever in	U.S. 13, Was Decedent of Hispanic Origin?		S • A •
or death v	1 Never Married 2 Married Armed Forces? 1 Yes 2XX No 3 Widowed 4 Divorced If Yes, Give Year	If Yes, specify Cuban, Mexican, Pue	erto Rican, etc.)	White, etc. Specify: White
ours aft	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	of work done 16b	. Kind of Business/Industry
5-0036 ed within 72 hours after than "matural" the Medical Examine Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) 2 years	Homemaker		Own Home
ed within the Med the Med Com	17. Father's Name (First, Middle, Last)		ame (First, Middle, Maid	en Surname)
MD 21215-0036 d 2 should be filed within 7 d 2 should be filed within 7 in 27 is marked other than umatic event, the Medica To Be Comple	John D. Davis	Carol 19b. Mailing Address (Street and Number	yn Vogel_	City or Town State Zip Code)
ID 21 should and Mg 77 is ma	19a. Informant's Name/Relationship (Type, Print) Christopher Clugston / spouse	'1		1
ore, MC es I and 2 s of Health at If item 27	20a. Method of Disposition 20	b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20	c. Location - City or Town, State
Baltimore, MD 2121 permit Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event.	4 Donation 5 Other Specify:	Inion Cemetery 5		Burtonsville, MD
mit.	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Donaldson Funer		
Physician	Gregory S. Karpman, per DVR M00770 23a. Part I. Enter the disease, or complications that caused the dea	ath. Do not enter the mode of dying, such as cardi	nue Laure Laure I ac or respiratory arrest,	Maryland 20707 shock, or heart Approximate Interval Between Onset and
'Modinal		f chronic alcohol abuse		Death
i zammer	or condition resulting in death) Due to (or as a consequence	e of):		
Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of the conditions).			
nsit Examine	C. Due to (or as a consequence events resulting in death) Last	ee of):		
and and Ex	d			
'60, ate be execute ohysician and ne burial - trar		3a,27, perME, g868, 6/29/07 T	Γ	23d. Date of delivery
5876 rtificate ling phy as the	23b. Was decedent pregnant in the 1 ✓ Live birth	2 Fetal death 3 Ectopic pr	regnancy	Month Day Year
the death certific the death certific by the attending is ched for use as the	1 ✓ Yes 2 No 9 Unknown g Unknown	of death 5 Other (Specify)		Mar 22, 2007
Records, P.O. Box 68760, The law requires that the death certificate be executed reach has been signed by the attending physician and page 2 should be detached for use as the burial - transi Completed by Physician/Medical E.	Part II. Other significant conditions contributing to death but n	ot resulting in the underlying cause given in Part I	.	cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
s, P.C uires that n signed id be deta			24a. Was an	24b. Were autopsy findings available
Records, The law requires ficate has been sig			autopsy performe	prior to completion of cause of death? No 1 Yes 2 No
Rec : The liftcate of, page	25. Was case referred to medical	26.Place of Death (C	1 ✓ Yes 2 heck only one)	No 1 Yes 2 No
Vital ysician ysician director				sidence 6 Other:
n of ving Ph	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe hov	injury occurred
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit ledical Certification: To Be Completed by Physician/Medical Ex	2 Assistant Investigation	At home, farm, street, factory, office building, etc.		eet and Number or Rural Route Number, City e)
De Hospital n 24 hours te Funeral oletely fille	4 Homicide	wledge, death occurred at the time, date and place on and/or investigation, in my opinion, death occu	e, and due to the cause(surred at the time, date an	s) and manner as stated. d place, and due to the cause(s)
To the Ho within 24 To the Fu completel:	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month, Day, Year)
	X W/ Sex/	O.C.M.E.	/	April 30, 2007
X	30. Name and address of person who completed cause of death ((Item 23a) iner 111 Penn Street, Baltimore, M	D 21201	
·	Susan Hogan MD. Assistant Medical Exami 31. Date filed (Month, Day, Year) 32. Registrar's Sig			
State Registrar	MAN O O OOO	18 Sunto		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend #23e&26 Per PHY G867 5 Certificate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ALSOTH Month **Physician** 20 2007 04 10:20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Baltimore Washington Medical Center
5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthda Glen Burnie If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/11/1908 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Min. 1**X** M 2□ F Months Hours Ohio 99 Director 214-24-8543 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he martine once. 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21060 U.S.A. Funeral 12 Proctor Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 8 Professor Chemistry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Elizabeth Stimson Clifford Corwin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lanny Court, Millersville, MD 21108 Katharine Dougherty, Niece 551 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Louden Park Cemetery 04/25/2007 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Olopandus 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ULMONAREP Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner 16ERCIUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA 1 Tyes 2XXo 3 Probably 4 Unknown CARAUCOMA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 💢 ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No မ reing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Phys Clar

State Registrar

31. Date filed (Month, Day, Year) MAY 02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAWEJWALA Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Richard A. Cole 28, April 2007 1:00P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care - Woodbridge Catonsville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F 213-14-5423 Director 89 19, 1918 Maryland Mar. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 □ No Maryland Directo n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 335 Martingale Avenue 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify White Completed by 3 ☑ Widowed 4 ☐ Divorced "natural", the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) and Mental Hygiene. Flaqman Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be William Cole ပ Bertha Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta D. Welck / Daughter 335 Martingale Avenue, Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State Glen Haven Cemetery 4 Donation 5 Other (Specify) 5/1/2007 Glen Burnie, Maryland 21. Surature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cy diac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a Examiner squentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner burial-tran Due to (or as a consequence of): Box 68760, nding physician pe Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No. P.0. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? or Vital Records, <u>۾</u> 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autonsy 1∐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 2 No Hospital: 1 ☐ Yes Other: 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this al or Atte...

Just after death...

Aeral Director; After th?

Aly filled in by the funer? 27. Many of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred Certification: Division X Natural 5 Pending investigation 1 Tes Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29b. Signatury 29d. Date signed (Month, Dav. Year) who completed cause of deam (Item 23a) (Type, Print) Bert maruli in Moveme

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State Registrar 31. Date filed (Month, Day,

Year.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** John Crotty 30 a^M APRIL 2007 2:51 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 06/06/1928 Year) Months Days Hours Min. 1 M 2 □ F 071-20-2237 78 New York Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant of Heatth and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits must be notified at **Funeral Director** MD N/A 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 911 W. Lake Avenue 21210 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Injury or other traumatic event, the Medical Examiner Black, White, etc. 1 ☐ Yes 2 [X If Yes, Give Year or Dates: 2 X No 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Be Completed by Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 5 Roman Catholic Priest 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter J. Crotty Genevieve Sullivan ပ da. Informant's Name/Relationship (Type, Prict) St. Joseph Society of the Sacred Heart Fellow Priest 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1130 N. Calvert Street, Baltimore, Department of Health Important: If Item 27 MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Niagara Falls, NY 4 ☐ Donation 5 ☐ Other (Specify) 05/07/2007 21. Signature of Funeral Service Licenses 22. Name and Address of Facility any In Leonard J. Ruck, Inc. Mapandu 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the meshock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Onset and Death () Much **Physician** /Medical **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as/a Examine a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Principle 1 Funeral Director: After this certificate has been signed by the attending physician and burial-trans and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy perform 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be 0 1 Tes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To Hepatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier CortifyIng Phys cian To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examir er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and nanner stated. (Check only one) within 24 29b. Signature 29c, License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person

Year)

31. Date filed (Month, Day,

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who completed cause of death (Item 23a) (Type, Print)

32. Regietrar's Signature

M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Month April 2007 12:15a M DERR ANN KERNS 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Howard 8125 Clifford Court Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 26, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1□M 2√F 1930 PA 76 180-22-2266 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No Laurel Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20723 U.S.A. 8125 Clifford Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ ※ o If Yes, Give Year or Dates: 1 Never Married 2KM Married 1 ☐ Yes 2XXIo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Grade 12 College (1-4or 5+) Manufacturing Executive Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Conroy Joseph Kerns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Laurel, Maryland 8125 Clifford Court 20723 John C. Derr spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State West Arundel Crematory 5/2/2007 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility al Home, P.A. / M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease Due to (or as a consequence of): Diabetes Mellitus Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hyperlipidemia Due to (or as a consequence of) if yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes XXNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ শo 24a. Was an autopsy 2**X X**Vo 1□ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

MD

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23s any injury or other traumatic event, the Medical Examiner must once.

Baltimore, Maryland 21215-0036

Directo

Funeral

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Completed

Be

with the Maryland

use as the burial-tran for page 2 should 24 hours after death.

e Funeral Director: After this certifical listely filled in by the funeral director.

Hospital or Attending Physician: The law requires that the death certificate be executed

has

Division or Vital Records, P.O. Box 68760,

by Physician/Medical Examiner Completed Be Medical Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 ☐ Unknown

1 X Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

25. Was case referred to medical examiner? 1 ☐ Yes 2XXIo

27. Manner of Death

5 ☐ Pending investigation 6 ☐ Could not be determined

2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 28a. Date of Injury 28b. Time of (Month, Day Year) Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home SXXResidence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number D 19220

Laurel, Maryland

Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year) April 30, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neil A. Meade, M.D.

31. Date filed (Month, Day, Year)

32 Registrar's Signature

9811 Mallard Drive

State Registrar

completely within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) April 2007 **Physician** 30° 1:40 Рм Dale Ethel /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Elkridge Howard 7305 Maplecrest Road 8. Date of Birth (Month, Day, Year)
Tan. 13, 1 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours 1 □ M 2 🔀 F 84 1923 MD 212-18-7473 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Elkridge 1 ☐ Yes 2X No MD Howard Pages 1 and 2 should be filed within 72 hours after death with the Mannent of Health and Mental Hyglene.
The marked other than "natural", or items 23a or 28a-f shans. If item 27 is marked other than "natural", or items 23a or 28a-f shary or other traumatic event, the Medical Examiner must be notified. Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21075 USA 7305 Maplecrest Road Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√∑ No Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ann Lance Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7305 Maplecrest Rd., Elkridge, MD Mary Keener Friend/Guardian 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of F
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/3/07 Metro Crematory Inc. Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
Gary L. Kaufman F. H. @ Meadowridge Mem. Park, Inc 7250 Washington Blvd., Elkridge, MD 21075 21. Signature of Funeral Service License tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final erebrovoscular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical Exami and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ odati 52 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an certificate has be irector, page 2 s autopsy performed? Yes 2 No 1□ Yes director, 25. Was case referred to medical examiner? 26. Place of Death Check o I one Other: 4 \(\text{Nursing Home} \) Hospital: 217 No 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 1 🔲 Inpatient 1 ☐ Yes Medical Certification: To this funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Funeral Dir completely filled in 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier On the basis of and manner sta

State Registrar 31. Date filed (Month, Day,

within 2

DHMH 17 Rev 1/2001

32 Registrar's Signature

29c. License number

00 Geise Rd

29d. Date signed (Month, Day, Year)

ES/005/20, COLOMBU

Please Type or Print in Black Indelible Ink.	Ensure All Copie	s Are Legible
		and the second of the second

		1 - For State of Maryland / Departm Certific	nent of Health and M cate of Death	lental Hygiei	L00/ 14004
Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
- /Medic	al	Colomba M. Esposito 4a. Facility Name (If not institution, give street and number) 4b. (City, Town, or Location of Death	April	4c. County of Death
Examin	er		Parkville	'	Baltimore
Funeral		1 M 2 F Mon		8. Date of Birth (Month, Day, Ye	ar) 9. Birthplace (State or Foreign Country)
Director		216-76-5856 The substitution of December 1 The Section 1 The Section 28 The Secti		10-14-19	Naples, Italy
if y fail (C. L. L. D-0030) should be filed within 72 hours after death with the Maryland and Mental Hyglene. The William See of 28e-1 show marked other then "naturel" or items 23e or 28e-1 show marked other then "naturel" or items 23e or 28e-1 show marked other then "naturel".	-	10a. State 10b. County 10c. City, Town or Location MD Baltimore	ı		10d. Inside City Limits 1
the M.	Funeral Director		f. Zip Code	100	Citizen of What Country?
with 3e or	i Dir	26 S. Highland Avenue	21224		USA
death ms 2	nera		Decedent of Hispanic Origin? (Spe , specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
s after or Ite	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Ye	es 21 No Specify:	i ilozif, oto.	Specify: White
hours.	ed b	3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's	Usual Occupation	16b	. Kind of Business/Industry
hin 72	Completed	(Specify only highest grade completed) (Give kind of life. DO NC	of work done during most of worki OT use retired)	ng	
ed with ygiene yer the	Con	8th Homem			In own home
be fitted High out of the out	Be	17. Father's Name (First, Middle, Last) Antonio Memoli		(First, Middle, Maid	
in yier	P	The state of the s	dress (Street and Number or Rura		mentieri
nd 2 s alth an 27 is:			Claremont St.		
as 1 a of Hez		20a. Method of Disposition 20b. Place of Disposition	(Name of C	Date 20c	. Location - City or Town, State
Page ment ent: If		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother (Specify) Entomb. Oaklawn	5/3/	2007 Ba	ltimore,MD
Dariffinore, Infarylating Z.1.Z.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show Importent: If item 27 is marked other then. Decentry injury or other treumatic event, Ite Madical Examiner must be notified at once.			ne and Address of Facility Jo S. Conkling	seph N. St. Balt	Zannino Jr FH imore,MD 21224
Pnysician /Medical Examiner		23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions.	mode of dying, such as cardiac of Heart For brillation	gi-lure	Approximate Interval Between Onset and Death
death certificate be executed eathroning physician and for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ictive pulm	noncry	Disane
	Physician/Med		pic pregnancy or (specify)		23d. Date of delivery Month Day Year
S, T es that igned b be deta	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying	ing cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?
require been sig				1 Tes	2 No 3 Probably 4 Unknown
The law requires that the law requires start the law seen signed by the bage 2 should be detach.	Completed			24a. Was an autopsy performed	
VILGI icien: T certificat ector, pa	a	25. Was case referred to medical	26. Place of Death	1 ☐ Yes 2 ☑ 1 (Check only one)	No 1 ☐ Yes 2, ☑ No
OI VIIA Physicien: r this certific ral director,	To B		DOA Other: 4 Nursing Hor	me 5 ☐ Residence	6 ☐ Other (Specify)
ing Phy Mter this		27. Manner of Death 1 X Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how in	njury occurred
Attending at death. ector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fa		28f Location (Street	t and Number or Rural Route Number,
ol or A ster after I Direct din by	Certification;	4 Homicide determined building, etc. (Specify)	istory, onlog	City or Town, Si	
the Hospitel or hin 24 hours afte the Funerel Dir npletely filled in	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occur of my knowledge, death occur one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occur of my knowledge,	rred at the time, date and place, ation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the within 7	Me	29b. Signature and inter of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
		Noun Handing 10 1/5.12	100 DS36	085 H	pric. 40 2001
3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	(es st. 42	02 B	altimore 2/204
Sta Registr		31. Date filed (Month, Day, Year) MAY 0 2 2007 32. degistrar's Signature	les .		

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 14066

		- For State egistrar		Cert	ificate of	Death		- 2	Re	g. No.			
Physician	1/	. Decedent's Name (First, Middl	· ·						Date of Death Month	Day Yea		3. Time of Death	
ledical Examine		Burton Echardt Hanna				April 14			April 14, 20	007		0057 hrs	
	4	4a. Facility Name (if not institution, give street and number) 16 Dunbale Road #210				4b. City, Town, or Location of Death TDWSON				4c. County of Death Baltimore County		ty	
Funeral Director		5. Social Security Number 21 5 – 54 – 7331		ge (In yrs. las 58	t birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	B.Aim		1, 1949	9. Birth Foreign Cour		
	\perp	Usual Residence of Decedent	IV WI Z F		115.			<u> </u>		1, 1212			
any	_	10a. State 10b. County		10c. City, T	own or Location	on					1	0d. Inside City L	imits
8	į L		imore	Tows	on							1 Yes 2 X	No
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once.	Funeral Director	10e. Street and Number 16 Dunvale Ro	pad			10f. Zip Code 21204			10	g. Citizen of Wh	iat Counti JSA	ry?	
with t ms 23a be not	a la	11. Marital Status	12. Was Deceden			Decedent of Hisp es, specify Cuban,					- America	n Indian, Black,	
ter death			1 X Yes 2	No No		Yes 2 Y No		derto Mic	an, etc.)	Specify:	₩hi [.]	to	
urs afl tural'	좕	15. Decedent's Education (Spe	or Dates:	mpleted)	16a. Decedent	's Usual Dccupation	on (Give kin			16b. Kind of Bu			
72 ho	ete 	Elementary/Secondary (0-12)	College (1-4 or	5+)		st of working life. I)	Tows	on Fo	rd	
5-0036 It hours after the within 72 hours after the water all the Medical Examiner.	Completed		1		Ma:	intenance						,, L G	
21215-0036 utel be filed within 7 Mental Hygiene e event, the Medica	Be C	17. Father's Name (First, Middle Burton E. Ha	· ·			1		othea		taiden Surname) tt)		
2121 ould be fill 1 Mental H s marked ic event, t		19a. Informant's Name/Relations				Address (Street			al Route Num	ber, City or Tow	n, State, 2	Zip Code)	
re, MD 21215 1 and 2 should be file If Health and Mental If item 27 is marked of or traumatic event, the		Gregory Hanr	na/Brother			BellFlow						392	
ages 1 and 2 shou nt of Health and Nt: If item 27 is not other traumatic	1	20a. Method of Disposition 1 Burial 2 Cremation	n 3 Removal from S	tate cr	ematory or oth				ate	20c. Location -	•		
E a a E F	4	4 Donation 5 Other S	ipecify:	Hi		Svc. Corp ame and Address			2/2007			Marylan	
Balti permit. Departn Import	ŀ	21. Sign re of Feneral Service	Licensee			ame and Address 50 York f							C.
Physician		23 V art I. Enter the disease, or failure. List only one cause		d the death. I	Do not enter th	e mode of dying, s	such as card	diac or re	spiratory arre	est, shock, or hea	art	Approximate In Between Onse	
/Medical. Examiner		Immediate Cause (Final disease	a. Smoke inha			mal injurie	es					Death	
		or condition resulting in death)	Due to (or as a cons	sequence of)	:								
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	sequence of)									
Mg B II	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
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ficate be expension of the purial streem the pur	ĕŀ	IF FEMALE:	23c. If yes, outco	ome or pregna	aricy					23d. Date of	delivery	-,	
687 ertific iding p	ian/	3b. Was decedent pregnant in t past 12 months?	Dress and	nt time of dea	4h	al death 3	Ectopic p	pregnancy	/	Month	Da	y Yea	г
Box 687 e death certifing the attending ed for use as t	Physician/Medical	1 Yes 2 No 9 Un	oknown 4 Pregnant a 9 Unknown	it arrie or ded	th 5 Oth	er (Specify)	·						
that the	by P	Part II. Other significant condi	tions contributing to dea	th but not res	sulting in the u	nderlying cause gi	ven in Part	l.		bacco use contri			
S, P		<u>Hypertensive</u> a	atherosclerotic	cardio	vascular	disease			1 Yes			bly 4 V Unkn	
cords,	Completed							_	24a. Was a autop	sy r		psy findings ava mpletion of caus	
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tal Recition: The certificate	8	25. Was case referred to medica examiner?					of Death (C	check only					
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n of V	ä	27. Manner of Death 1 Natural 5 Pen	28a. Date of In (Month, Day	jury Year)	28b. Time of Ir		y at Work?			now injury occurr		11. 6	
SiOf Attend death cetor:	lă:	TO FEII	Fnd 4.14		Fnd 12:39	7 dill	es 2 X N			nvolved in			
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death. For all Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detact	Certification:	dete	uld not be ermined (Specify) re			t, factory, office bu	marrig, etc.		or Town, S				, City
hou hou		4 Homicide 29a. Certifier (Check only 1 Certifying P	Physician: To the best of	ny knowledg	e, death occurr	red at the time, dat	te and place	e, and du	e to the caus	e(s) and manner	as stated	i.	
To the How within 24 h	Medical	one) 2 Medical Exa 29b. Signature and title of certifi	aminer: On the basis of ex and manner stated	amination an	a/or investigati	on, in my opinion, 29c. License		ured at th	e time, date a	29d. Date sign			
	-	200. Signature and the or certifi	/ >/- /			O.C.N				April 14, 20		, 20j, i var/	
30. Name and address of person who completed calls of death (Item 23a)													
Chra/ D		Theodore M. King, Jr		Medical E		111 Penn Stre	eet, Balti	imore, I	MD 21201				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			ricasc	State of Maryland		nt of Hoolth and	-		
			1 - For Stete Registrar	State of Marylant		te of Death		eg. No.	14067
			1. Decedent's Name (First, Middle, La	st)			2. Date of Deat	th	3. Time of Death
	Physici /Medio		George	- J. Haas	S		Apr.	29 2007	11:20 pM
)	Examir	er	4a. Facility Name (If not institution, give	e street and number)	4b. City	, Town, or Location of Deat	h /	4c. County of Death	,
			5. Social Security Number 6. S	9x 7. Age (In yrs. 12	ast birthday) If Und	or 1 Year If Under 24 Hrs	8. Date of Birth	Harca	place (State or Foreign
-	Funeral Director			MM 2□F	Yrs. Months			Year) Coy	imore MD
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County	10a City	, Town or Location				,
	Aaryla f ahou	ō	MA Hacfa	d	Forest	4:11			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	r 28e	Director	10e. Street and Number	α		ip Code	1	0g. Citizen of What Cou	
	hours after death with the Maryland tural, or Items 23a or 28e-f ahow al Exact ar must be notified at	a D	1116 Sunsh	ine Ct.		21050		USH	7
	Hems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13. Was Deo If Yes, sp	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer	specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White	
3	I', or I	byF	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No It Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify:	rite
2-0036	72 hours "natural", adical Exe	ted	15. Decedent's Ed	fucation	16a. Decedent's Us	ual Occupation		16b. Kind of Business/Ir	ndustry
7	d within 72 ho piene. r then "netur r e Medicel	Completed	(Specify only highest gra	College (1-4or 5+)	life. DO NOT	ork done during most of wo use retired)	rking	0 11-	0.1
7 0	filed w Hygier other ti		17. Father's Name (First, Middle, Last)		tice tigh	Ites	ne (First, Middle, M	Coultinore	city
au	o ii o	To Be	Christian	Hans	0	/11.16	- 00 0 N	ia Ehe	+
Mary	should and Men marke umatic	_	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addres	s (Street and Number or Ri	ural Route Number,	City or Town, State, Zij	Code)
	s 1 and 2 shou f Health and N item 27 is mai other trauma		Margaret Haa	5- Souse	MIG S	unshine C	t. Fore	STHIL M	021050
o e	00		20a: Method of Disposition 1 Burial 2 Cremation 3	1 60	ace of Disposition (Nametery, crematory or	other place)	Date :	20c. Location - City or T	own, State
altimore,	그투원을		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer			hapol-BellAir 5	11/07	Forest H	11, nu
g	Departiment of the post of the		Kim by last	To belle	_	100	4 45	s Forest Hill	22 a 22
			23a. Part1. Enter the dise use or comshock, or heart failure. List only	plicar ns that caused the eath.	Do not enter the mo			mation sek	Approximate
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	/Medical Examiner		resulting in death)	Due to (or as a consequ				3	NCS
	Lxummer	-	Sequentially list conditions,	b. Dille to (or as a conseque	or now the				
4	uted ansit	Examiner	Sequentially list conditions, 1 any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	330 10 (01 33 4 25) 350(4					
oʻ	be executed iicien and burial-transit		resulting in death) Last	Due to (or as a consequent	ence of):				
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χ X	certificat nding phy use as th	by Physician/Med	IF FEMALE:	22a If you gutoome of program					133334.0
ğ	death of etten	cian	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ectopic			23d. Date of deliver Month	ery Day Year
j.	t the c by the	hysi	9 Unknown	9□ Unknown		//			
, T	w requires that the death been signed by the ette should be detached for	by P	Part II. Other significant conditions c	ontributing to death but not resul	lting in the underlying	cause given in Part I.	23e. Did tob	acco use contribute to t	
cords	requir	sted					1 🗆 Ye	es 2.⊠No 3.∏Prot	pably 4 □Unknown
ဥ	28 8	Completed					24a. Was ar autops perform	v prior to co	ppsy findings available impletion of cause of
VIII	pa es	ပိ	25. Was case referred to medical				1 ☐ Yes 2	No 1 ☐ Yes	2□ No
	Physicien: this certific ral director.	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3□ D	Other	ath <i>Check only one</i> Iome 5 ☐ Reside	nce 6 ☐ Other (Special	(v)
ō =	ng Ph fter th		27. Man of Death 1 VNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		w injury occurred	,,
<u> </u>	tendi Jeath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be		М	1 ☐ Yes 2 ☐ No			
UIVISION	after of Direction by	Certification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, street, facto	ry, office	28f. Location (Str City or Town	reet and Number or Rura , State)	al Route Number,
	To the Hospital or Attanding Phys within 24 hours attended the Total Funeral Director: Afler this completely filled in by the funeral directors.		29a. Certifier 1 Certifying Ph	ysician: To the best of my know	rledge, death occurred	d at the time, date and place	, and due to the ca	use(s) and manner as s	tated.
	the Ho nin 24 the Fu	ledicai	one	ninar: On the basis of examination and manner stated.	on and/or investigatio	n, in my opinion, death occu			
	To with	Σ	29b. Signature and title of certifier	Kohert	4 Dorch	c. License number	29	9d. Date signed (Month,	Day, Year)
•			30. Name µnd address of person who	completed cause of death fite-	23al (Type Dring)	LOISK		1->0.4	
	12+1		615 W. W	1 CRANT	29 B	DiAm.	W 2	1014	
	Sta		31. Date filed (Month, Day, Year) WAY 0 2 2007	32. Registrar's Signatu	110 hails	V 1	-		
	Registr	al 💮	ואבני עם בטטו	Process of the same					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Deal 1. Decedent's Name (First, Middle, Last) Day 2:35 P. M Theodore Franklin Hoefler, Sr. 24 2007 April 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Months Days 1**Ϫ**M 2□F 74 216 28 3216 31. 1932 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 10a. State 1 ☐ Yes 2 X No Maryland Anne Arundel Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5809 Park Road 21225 U.S.A. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 X Yes 2 No
If Yes, Give Korean
Year or Dates: 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Construction 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Max Hoefler Mechtilda Schmitt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey Hoefler / wife 5809 Park Road Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 4/28/2007 | Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PNEUMUNIA MOUTH disease or condition resulting in death) Due to (or as a consequence of): Y CARS ANCREATIC CANCE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dunitu (ur as a consecuence of) Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? AJBESTOSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CURMARY ARTERY DIJEMSE 24a. Was an performe BROWCHITU CHRONIC 1 | Yes 2 | □ 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Hipatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27, Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation

Examiner use as the burial-transit death certificate be executed and Box 68760. nding physician atter for u P.O. been signed by the should be detached Division or Vital Records, s certificate has t lirector, page 2 s To the Hospital or Attending Physician: director,

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28a-f show

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permit. Pages 1 and 2 Department of Health s Important: If Item 27 is any Injury or other tra

Physician

/Medical

Baltimore, Maryland 21215-0036

Director

Funeral

2

Completed

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Examine

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Certification:

"natural", or items 23a or 28a-f sh edical Examiner must be notified

traumatic event, the Medical

1 ☐ Yes

2 ☐ Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

1 Yes 2 No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier MD 2

6 Could not be determined

00051437

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

BITOTE State

ANNAPULLS AAMC

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 2100 201 2007 elvin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 6825 Campfield Rd. Apt. 10-T Baltimore Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Hours 18 M 2□ F 1254-01-615 93 Aug 22, 1913 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County r than "naturel", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6825 Campfield Rd. Apt 10-T 21207 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: À White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Elevator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fi f Health and Mental H item 27 Is marked off Be Otto Frederick Hildebrand Amelia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 W. Hill St., Baltimore, MD Melvin O. Hildebrand, Jr.-son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Importent: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 5/3/07 Parkville, MD 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MINUTE myacardia /Medical Due to (or as a consequence of): Examiner Social traity list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown icate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 22 No Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 No After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification: 1-12 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide hours after within 24 hours a To the Funerel D 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal completely (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D37577 30,7007 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 10 MD 21136 Main MD 25 CIPAL 31. Date filed (Month, Day, Year)-32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2007m Hynes R 200 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death N/A Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) June 21, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1 🕅 M 2 □ F 213 62 6273 53 Maryland 1953 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 851 West 33rd Street 21211 U.S.A. 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 👿 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Distribution Warehouse worker 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Diania Burton John L. Hynes, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21225 Sherry Kelly / Daughter - 12th Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 5/2/2007 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signatur of Euneral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) meumonia 5 dai Due to (or as a consequence of): nodeficiency syndrome tive pulmonary disease immu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform

Physician /Medical **Examiner**

attending physician and for use as the burial-tran

been signed by the should be detached

certificate

this

After

within 24 hours after death

To the Funeral Director:
completely filled in by the

Hospital

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Certification:

Medical

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Department of H Important: If ite any injury or ot once.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examiner Physician/Medical IF FEMALE: <u>م</u> Completed

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 2 No 1 Tyes

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

5 Pending investigation

6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

2 No

Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 ☐ Yes 2 ☐ No

 Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifie

2007

29d. Date signed (Month, Day, Year)

of person who completed cause of death (Item 23a) (Type, Print) 30. Name and

Hospital:

Union Memorial Registrar's Signature Month, Day, 31. Date filed

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7.55 A M amil 25 2007 lannotti Ineresa Marie /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bultimore City The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗷 F Yrs. 48 1/11/58 Director 264-35-2326 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 No Director Orange Orlando 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pe J must 32832-5956 USA 10208 Sandy Marsh Lane Funeral 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after deat Inopartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any Injury or other traumatic event, the Medical Examiner many Injury or other traumatic event, the Medical Examiner many. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: 3altimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be <u> Alma M. McDermott</u> <u>Joseph Anthony Giunta, Sr.</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Frank Iannotti / Husband 10208 Sandy Marsh Lane Orlando, Flordia 32832-5956 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore Crematory 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/26/07 Loudon Park Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Enjer the disease, of shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Gram Neative Backerenia 48 hours /Medical Due to (or as a consequence of): Examiner Treatment Refractory actite Mycloid Loukenia 3 mouths if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should it Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 No 1□ Yes 2⊠No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. e Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical within 24 ho

To the Fune

completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

10

State Registrar

31. Date filed (Month, Day, Year)

Reizabeth alice griffths, Medical Doctor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ELIZABETH GRIPATHS, OUTPATIENT SERVICES WEINBERG BULDING 401 NORTH BRUHDNAY, BALTIMORE, MARYLAND 21231 32. Pegistrar's Signature

063950

april 25 2007

07-03285								
Michael Johnson								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ichael Johnson		1- For State	Certificate of D	leath	rygiene Reg	200	7 1407		
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death		
ledical Exami		MICHAEL	JOH	NSON	Month E April 30, 20	Day Year 07	0045 hrs		
		4a. Facility Name (if not institution, give street and number 1338 Stevens Avenue		City, Town, or Location of Dea Arbutus	th	4c. County of Death Baltimore Cou			
F					rs 8 Date of Birth	(MM/DD/YYYY) 9. Bir			
Funeral Director		214-88-3874 1XM 20F	· · · ·	Months Days Hours Mi		Foreig			
aus		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location		\		10d. Inside City Limits		
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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tell and Mental Hygiene. ten 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once.	Director	10e. Spreet and Number 7216 STONISARI	ROAN	Df. Zip Code	14	Citizen of What Cou	ntry?		
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and 2 should fealth and N tem 27 is n traumatte		1 A MEAKA D. JOHNSON	20b. Place of Dispositio	STONYBARI n (Name of cern/etery,		20c. Location - City or	101.1		
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Balti permit. Departn Importi injury	5 /	alqueliet. Nou	ne 31	到 对 总元	ROWN .	BALTO.	4021217		
Physician		23a. Part/. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do not enter the	mode of dying, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and		
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Division of Vital Records, pital or Attending Physician: The law requirement after death. reral Director After this certificate has been si filled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined (Specify) Ba	njury - At home, farm, street, [.] ar/ tavern	factory, office building, etc.	or Town, Sta	reet and Number or Ru ate) Avenue, Arbutus, M	ural Route Number, City		
Division of Vital Records, P.O. Box 68760, and the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical C	29a. Certifier 1 Certifying Physician: To the best of mone) Certifying Physician: To the best of mone)	amination and/or investigation						
To Cor	Mec	29b. Signature and title of certifier	·	29c. License number		29d. Date signed (Mo	nth, Day, Year)		
		Thoda U. Thing T	Ma was	O.C.M.E.		April 30, 2007			
/ h		50. Name and address of person who completed ause of Theodore M. King, Jr., MD. Assistant M.		11 Penn Street, Baltimo	ore, MD 21201				
J	tate		ar's Signature						
Regis	trar	MAY 0 2 2007 / June	is it spen	<i>U</i>					
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Edward Wayne Johnson 07-03286 Places Turns

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

IK UNK	1- For State	partment of Health and Mental Hy ertificate of Death	giene 2007 1407
Physician		:	2. Date of Death 3. Time of Death
edical Examine	BEWIND WILLIE COMMON!	4b. City, Town, or Location of Death	April 30, 2007 0045 hrs
	4a. Facility Name (if not institution, give street and number) 1338 Stevens Avenue	Arbutus	Baltimore County
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthday) If Under 1 Year If Under 24Hrs.	Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director	218-96-7738 1XM 2F 25	5 Yrs. Months Days Hours Min.	5-23-1981 Foreign Country) MD.
any	Usual Residence of Decedent 10a. State 10b. County 10c. Ci	ity, Town or Location	10d. Inside City Limits
	MD. N/A	BALTIMORE	1 X Yes 2 No
farylar 28a-f s at on	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
ith the Maryland 23a or 28a-f show notified at once.	1003 BETHUNE RD.	21225	USA
72 hours after death with the Maryland n "matural", or items 23a or 28a-f she al Examiner must be notified at once letter hy Etuneral Director	11. Marital Status 1 X Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto F	
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- 모품 모종	TENNILLA RUMPH(SISTER) 20a. Method of Disposition 20	1375 PENTWOOD AVE BA 1b. Place of Disposition (Name of cemetery,	LTIMORE, MARYLAND 21239 Date 20c. Location - City or Town, State
Baltimore, Department of Hee Important: If ite	1 XBurial 2 Cremation 3 Removal from State	crematory or other place)	
Baltimore permit. Pages I Department of F Important: If injury or other	4 Donation 5 Other Specify: 21. Signature of Fundral Service Licensee JON THAN D.		-2007 BALTIMORE, MARYLAND LLIPS FUNERAL HOME, P.A.
Balti permit. Departir Imports injury o	frath () Hu	3 1721-27 N. MONROE	ST. BALTIMORE, MARYLAND 21217
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	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause	ee of):	
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S, P.C uires that a signed lid be deta			1 Yes 2 No 3 Probably 4 ✔ Unknown 24a. Was an 24b. Were autopsy findings available
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tal Records, tian: The law require certificate has been si ector, page 2 should be considered.		0.00	1 Yes 2 No 1 Yes 2 No
of Vital ig Physician: the this certi	25. Was case referred to medical examiner? Hospital: Inpatient 2	26.Place of Death (Check of De	Home 5 Residence 6 ✔ Other: Scene
of Vi	27 Manner of Death 28a Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred Subject sustained blunt force injuries and was
ion Itendii Ieath. Itor: /	1 Natural 5 Pending Apr 30, 2007 Pending 2 Accident Investigation	1 Yes 2 No	shot
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To wit	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	I header M. KIT The	o.C.M.E.	April 30, 2007
\	30. Name and address of person who completed cause of death (In Theodore M. King, Jr., MD. Assistant Medica		e, MD 21201
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 04/29/2007 **Physician** Kenneth Karns 9:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fairfield Nursing Home Anne Arundel Crownsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 219-38-3297 Yrs 66 Director 07/06/1940 MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other treumatic avant, the Madical Examiner must be notified at 1 ☐ Yes 2X No Director MD Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? P.O. Box 65 21032 USA or itema 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene, important: if item 27 is marked other than "natural", or Item eny injury or other fraumatic. Black, White, etc. Affred Folces: 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify Specify: White 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Karns Helen Wagener 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister 735 Herald Harbor Road, Crownsville, MD 21032 Diana Karns 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 105/02/2007 Elkridge, MD Meedowridge Memorial Park Gary L. Kaufman Funeral Home at MMP, INC 7250 Washington Blvd., Elkridge, MD 21075 21. Signature of Funeral Service Licensee M01378 M01378 7250 Washington Blvd., Elkri and Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2109 /Medical Due (o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the attending physicien and The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ٥ Day Year Month 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No deteched P.O. 9 Unknown 9 Unknown ۾ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1☐ Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 2 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification; After Injury 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident Diractor: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dirac 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of c 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rain Highway Oly Burne MD21061 el State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AF'RIL Day Physician 02:54P M 2007 Mary Jane Lurz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 02/01/1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months Maryland 214-24-8728 81 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director Timonium MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21093 2300 Dulaney Valley Road Apt. K104 U.S.A. by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other than "natu vent, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Fis marked of Elmer John Schmitz Emma Noonan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau Joseph M. Lurz, III, Son 13582 Windview Court, New Freedom, PA 17349 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Joseph Fullerton 04/30/2007 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. asta Pandroxell 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) STROKE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, physician s the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by HYPERTENSION 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

DHMH 17 Rev 1/2001

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State

Registrar

29b. Signature and title of contific

30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print)

M. D. 76.01 32. Registrar's Signature

Colores

29c. License number

7601 OSLER DRIVE TOWSON.

D46356

MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Month AFRIL Physician Dorothy Elizabeth Lilly 8:30P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Baltimore Saint Joseph Medical Center 7. Age (In yrs. lat 88 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. 6/3/1918 9. Birthplace (State or Foreign 5. Social Security Numbe 6. Sex last birthday) **Funeral** Months 220-30-5683 1 ☐ M 2 🛣 F Marviand Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits a or 28a-f show t be notified at 10a. State 10b. County 1 ☐ Yes 2 No Towson Director Baltimore MD 10e. Street and Number 10f. Zip Code 21286 10g. Citizen of What Country? with permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if item 27 is marked other than "... any injury or other traumation. 1000 East Joppa Road USA "natural", or items 23a Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2√XNo Specify: Specify: þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Dona Sause Be (Leo Scharfe ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fallston, MD 21047 2112 Hampton Court Robert Lee Lilly / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 5/4/2007 Loudon Park Cemetery : 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Welther Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ISCHEMIC CARDIOMYOPATHY /Medical Due to (or as a consequence of): Examiner CORONORY ARTERY DISEASE Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner anding physician and use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, ₼ Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. END — STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 54M0 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA P this 27 Manner of Death 1 Natural 2 Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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31. Date filed (Month, Day, Year) State Registrar

ARDALLAH

29b. Signature and title of certifier,

76Ø1 OSLER DRIVE TOWSON, MARYLAND 21204 egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D17695

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death APR Year **Physician** 17 30 M MILTON LEVITT 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE SAINT AGNES NONE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1X M 2□ F 078-26-9045 75 06/01/1931 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD BALTIMORE CATONSVILLE 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 717 MAIDEN CHOICE LANE, ST. 420 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE Specify: Completed by 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **UPHOLSTERY** owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LEVITT EVA BLUMENFELD 2 or Rural Route Number, City or Town, State, Zip Code) ANE, ST. 420 228 19a. Informant's Name/Relationship (Type. Print) Address (Street and Number of IDEN_CHOICE VILLE, MD 21 SUZANNE LEVITT / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place ARL INGTON CEMETERY CHIZUK AMUNO Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/01/2007 BALTIMORE, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** PHEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of) MONIHS Examiner PARKINSON Sequentially list conditions, if any leading to find the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an was an autopsy performed?
Yes 2 2 No page 2 1∐ Yes or Vital director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Division 5 ☐ Pending investigation Iniury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD. 29 2001 20655

Registrar

State

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MAY 0 2 2007

CATON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVE

32 legistrar's Signature

BALTIMORE

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MD

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			1 - For Stete Registrar	State of M		d / Depa		t of H	ealth a	and M	, ,	•	7	14080
			1. Decedent's Name (First, Middle	e, Last)		-					2. Date of Deat Month	th Day	Year	3. Time of Death
	Physici /Medio		Louis F.	Miller	Jr.							30, 200		2:20 p ^M
	Examin		4a. Facility Name (If not institution	, give street and number	-)		4b. City,	Town, or	Location of	of Death		4c. County	of Death	
		**	Glen Meadows					en A				Ba	ltim	
	Funeral Director		5. Social Security Number 084-14-9692	6. Sex 7. A	ge (In yrs. la 87	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Oct 27,	1919	9. Birthp Coul Net	place (State or Foreign ntry) York
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	Town or Lo	cation							10d. Inside City Limits
	death with the Maryland rms 23a or 28e-f show rmust be notified at	5		altimore	, , ,	Glen								1 ☐ Yes 2 ☐ XNo
	the 1286-	Funeral Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of V	What Cou	ntry?
	3a or		11630 Glen A	rm Road			,	210	57			-	S.A.	,
	death ms 2	era	11. Marital Status	12. Was Deceden		3. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)			can Indian,
9	after or ita		1 ☐ Never Married 2 ☐ Marr	ied 1 Yes 2 [T '	r Yes, spec 1 🗌 Yes 2			i, Pueno	Hican, etc.)		k, White,	
93	hours after turef, or ita	db	3 Widowed 4 Divorced	Year or Dates	:				Specify:			Specify	· W	nite
5-	72 h "netu	ete	15. Deceden (Specify only highe:	t's Education st grade completed)		16a. Deced (Give life. I	dent's Usua kind of wor	l Occupa k done d	ation <i>Juring mos</i>	t of work	ing	16b. Kind of Bu	usiness/In	dustry
121	within ene. then "	Completed by	Elementary/Secondary (0-12)	College (1-4or	5+)		& Die					Fed	eral	Government
d 2	filled Hygi other	ပိ	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle, M	Maiden Suman	ne)	
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Mental Hydene. If item 27 is marked other then "neturet", or items 23a or 28e-1 show or other treumetic event, II a Madical Exertir erroral Le notified at	To Be	Louis F.	Miller,	Sr.	10h Mailin		(0)		heri				ansen
Ma	d 2 sho th and ?7 ie my treum		19a. Informant's Name/Relations Linda M. Rubeo:								al Route Number ISON, MD	21286	State, Zip	Code)
	is 1 and of Health item 27 othar tr		20a. Method of Disposition	r-daugitter	20b. Pla	ace of Dispo metery, crer				181		20c. Location -	City or To	own, State
Ω	ages ant of nt: If if		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		3 1	_{metery, crer} hview				5/5/		Fallst		
Baltimore,	parmit. Pages Department of I Importent: If ite any injury or of		21. Signature of Funeral Service											ome, Inc.
ä	parmi Depa Impo any ii		1/1/11	WITITE	. u. D						son, MD	21±20		Jille, Trie.
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7	/Medical		resulting in death)	d	s a conseque		-						- 6	, , , , , , , , , , , , , , , , , , , ,
80	Examiner		Sequentially list conditions.	b										
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) P_	ba executed ician and burial-transit	xarr	that initiated events resulting in death) Last	c. Due to (or a	s a conseque	ance of):								
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687	icate phys s the			d										
×	certif nding se a	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnan	су						23d Dat	e of delive	nr.v
Вох	death certifica e attending ph d for use as th	ciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pro Other (spe					Mo		Day Year
0	t the c by the achec	Physician/Med	9 Unknown	9□ Unknown										
ď.	requires that the een signed by th nould be detache	y P	Part II. Other significant condition		but not resul	ting in the ui	nderlying ca	ause give	n in Part I.		23e. Did tob	acco use conti	ribute to tl	he cause of death?
Vital Records,	w require been sig should b	Completed by	ardismysp	any							1 □ Ye	s 2□No	3 Prot	pably 4 Dinknown
900	aw as b	piet	Generation.	V					4		24a. Was ar		Vere auto	ppsy findings available impletion of cause of
Ä	The Tate has page	Com	Charmi Oss	bruture	Pul	mes	ay		Ise	as	perform	ned2 c	leath?	2□No
/ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only on			
of V		2	1 ☐ Yes 2 ☐ No		ient 2 E			_	41 Nu	rsing Ho	me 5 ☐ Reside	nce 6 Oth	er (Specif	(y)
n		on:	27. Manual of Death 1 Natural 5 ☐ Pendin	g 28a. Date of Inj (Month, D	ay Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe ho	w injury occurr	ed	
Sic	Attending r death. sctor: Afte	cat	2 Accident investig	not be			M		/es 2□	1	004 Lassias (Ct			1.D
Division	or Al	ertif	4 ☐ Homicide determ	ined 28e. Place of Ir building, e	itc. (Specify)	ne, ramn, str	eet, ractory,	, описе			28f. Location (Sti City or Town	, State)	er or Hura	ai Houte Number,
_	spital ours sours a	20	29a. Certifier 1 Certifyin	g Physician: To the bes	t of my know	rledge, death	occurred a	at the tim	e date an	d place	and due to the ca	ause/s) and ma	nner as s	tated
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by tha	Medical Certification:	(Check only 2 Medical one)	Examiner: On the basis and manner s	of examination	on and/or inv	estigation,	in my op	oinion, dea	th occurr	ed at the time, da	ate and place, a	and due to	o the cause(s)
	To To t	2	29b. Signature and title of certifie	S (IN N	m)		290	License	number	2	29	9d. Date signed	(Month,	Day, Year)
•			· /VVVVX	W 1			10	36	43	>	/	nyy	1,0	LOUT
	10H		30. Name and address of person M M M D	Common C.	670	1 1	Print) V CH	ARC	ES	81	BAL	IMOR	E	M9 21204
	Sta Registr		31. Date filed (Month, Day, Year)	2 2007 32. Total	trar's Signatu	k A	est o							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) -63PM Physician MISNER Linda BPn 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard County General Hospital Howard Columbia If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Hours 1 ☐ M 2 X F 217-42-8939 62 01/09/1945 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 X No Elkridge MD Howard **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 6636 Washington Blvd 21075 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Specify: White 3 ☐ Widowed 4 ☐ Divorced al Hygiene. I other than "natura vent, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Customer Service Food Service ulth and Mental Hygie 27 is marked other r traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pearl Brice Albert Misner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) D partment of Health ar Ir portant: If item 27 is any injury or other traconce. 6636 Washington Blvd., Elkridge, MD 21075 Misty Horn Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 5/2/2007 5 Other (Specify) Metro Crematory Catonsville, MD 4 ☐ Donation ^{22. Name and Address of Facility}
Gary L. Kaufman Funeral Home at MMP, INC.
7250 Washington Blvd., Elkridge, MD 21075 21. Signature of Funeral Service Licensee M01378 | 7250 Washington Blvd., Elkric
23 Part: Enter the disert, or the lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failur. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physician ar s the burial-t Division or Vital Records, P.O. Box 68760, attending pny IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kamesh Sabapathr

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ompleted cause of death (Item 23a) (Type, Print)

201-109 Back Rever Neck Koad Balhmore Maryland 21221

MAY 8 2 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, per Inf. C867, 5/19/07 TT

State of Maryland Department of Health and Mental Hygiene 11 7 1 1 8 2

			1- For Amend Item Registrar	24a,26 pei	veri	5. , gg	7, 05, 102, tificate of	767dhb Death	wientai my	gierte U ∪ Reg. No.	1	14002
			1. Decedent's Name (First, Middle, La	st)					2. Date of Dea	ıth		3. Time of Death
	Physici /Medic		Robert N. Messi	lck					Month April	Day 23, 2007	Year 7	3:10 PM M
	Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, o	or Location of Deat		4c. County		-J. IU FM
			William Hill Ma	nor			East	on		Talb	ot	
	Funeral		5. Social Security Number 6. S			t birthday)	Il Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	1		ace (State or Foreign
	Director		218-20- 9560	I <u>X</u> M 2□ F	79	Yrs.			May 14		Mary!	
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation				11	Od. Inside City Limits
	eho	5	MD Talbot		. co. oxy,	East						1 ☐ Yes 2√☐ No
	28a-f	ect	10e. Street and Number							10. 000		
	with a or 3	Funeral Director		2 - 1			10f. Zip Code			10g. Citizen of W	nat Coun	try?
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	ter d	Ë	1 ☐ Never Married 2 📉 Married	Armed Forces?		13.	Yes, specify Cubi	tispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	Black	k, White,	
38	urs af		3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates:	WWII		☐ Yes 2X No	Specify:		Specify:	whi	te
21215-0036	72 hours after death with the Maryland Inatural, or Items 23s or 28s-f ehow Jisal Examilitation and be multised at	Completed by	15. Decedent's E	ducation		16a. Deced	ent's Usual Occup	pation		16b. Kind of Bu	siness/Ind	ustry
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	be filled htal Hygid ed other event, II	Be	17. Father's Name (First, Middle, Last,)				18. Mother's Nar	ne (First, Middle,			
<u>ā</u>	ould b Menta	ToE	Walter Messick					Lotti	e Smith			
Maryland	and less ma		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street	and Number or Ru	ıral Route Numbe	r, City or Town, S	State, Zip	Code)
	and alth		Claudia Messick/s	spouse		25776	Royal O	ak Road	Easton.	MD 2160	1	
ore	of He		20a. Method of Disposition	Damaral from Ctata	20b. Plac	e of Dispo	sition (Name of natory or other place		Date	20c. Location - (City or Tov	wn, State
Ĕ	Pages nent of ant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ • 4 🛣 Donation 5 ☐ Other (Specif			•		, I				
Baltimore,	permit. Pages 1 and 2 should be illed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23e or 28e-f ehow any injury or other traumatic event, the Macical Extendible 1 as the nutitied at once.		21. Signature Luneral Service Licer Ronal & S	wate. Dire	ctor	22 S.t	Name and Addre	ss of Facility Omy Board	4 655 TT	D-1+4	0	
-	90 = 99		Jenn//	1 Jola		Ba	1timore,	MD 2120	01 w.	baltimo	re S	treet
			23a. Part Enter the disease, or com shock or heart failure. List only	plications that caused to	he death.	Do not ente	er the mode of dyin	ng, such as cardiad	or respiratory are	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	(3AA A	lin no	20121	an	0 -/-			Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequer	nce of):	Jugar	7 0001		. 0		reasons,
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	tificate be executed g physician and as the burial-transit	am	Cause (Disease or injury that initiated events resulting in death) Last	c				acul	Woling	nay ede	ma	Joans
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	ertific ling p		IF FEMALE:	20 - If								
BO	ath cuttend	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	Fetal de	ath 3	Ectopic pregnancy	1		23d. Date Mon	of deliver	y Day Year
<u>.</u>	Attending Physician: The law requires that the death cen ractors. After this certificate has been signed by the attendin by the funeral director, page 2 should be detached for use	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	me of deat	h 5□	Other (specify)					, , , , , , , , , , , , , , , , , , ,
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<u> </u>	: The	S		U					perfor 1 ☐ Yes		eath? □ Yes :	2□ No
ij	ttending Physician: The loath. tor: After this certificate he the funeral director, page	Be	25. Was case relerred to medical examiner?	Hospital:			0#		ith (Check only or			
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Ĕ	ing A	lo	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	Bb. Time of Injury	28c. Injun Work		28d. Describe h	ow injury occurre	ed	
Sic	tend death tor: ,	cat	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 □ No	201 1 11 12			
Division of Vital Records, P.O. Box	i Site	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	(Specify)	e, Iarm, stre	et, lactory, office		City or Tow	treet and Numbe n, State)	r or Hurai	Houte Number,
_	pital ours a eral		29a. Certifier 1 Certifying Ph	ysician: To the best of	mu ka awla	daa daath	annument of the time	and the said wilder				
	a Hos 24 hos Fun etely	ledical	(Check only 2 Medical Exam	niner: On the basis of e	examination	and/or inv	estigation, in my o	pinion, death occu	red at the time, d	ause(s) and man ate and place, ar	nd due to	the cause(s)
	To the Hospital or At within 24 hours after C To the Funeral Dirac completely filled in by	₩	29b. Signature and title of certifier	/ / 00			29c. License	e number		9d. Date signed	(Month, D	Pay, Year)
	. , - 0		1 m N	Woods	MI)	I	74871		1//-	73	100
			30. Name and address of person who	completed cause of dea	th (Item 23	Ba) _e (Type, F	Print)			1		10/
			William H	1. WC	00	\mathcal{A}	2h	Willi	Am 1	V/11.	MA	NON
	Sta	te	31. Date liled (Month, Day, Year)	32. Registrar			A		* (- 1	· · · · · · · · · · · · · · · · · · ·
	Registr	ar	MAY 0 2	2007	wer ,	A. A.	2342					

24a.

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

Director

Funeral

Be Completed by

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Examiner

Physician/Medical

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1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or: any injury or other traumatic event, the Medical Examiner must be nonce.

and burial-tran the attending physician the cate has been signed by t page 2 should be detach certificate After this

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

ted					1 ☐ Yes 2	No 3 Probably 4 Unknow
Complete					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Be	25. Was case referred to medical examiner?			26. Place of Death	(Check only one)	
P	1 ☐ Yes 2 No	Hospital: 1 ☐ Impatient 2 ☐ ER/	Outpatient 3 □ DOA	Other: 4 Nursing Hon	ne 5 Residence 6	G ☐Other (Specify)
cation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) on	b. Time of 28c. Injury M		8d. Describe how injury	
Certific	3 ☐ Suicide 6 ☐ Could not be determined		, farm, street, factory, o	ffice 2	8f. Location (Street and City or Town, State)	d Number or Rural Route Number,
edical (29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the best of my knowled miner: On the basis of examination and manner stated.	dge, death occurred at and/or investigation, in	the time, date and place, a my opinion, death occurre	nd due to the cause(s) ed at the time, date and	and manner as stated. place, and due to the cause(s)
ž	29b. Signature and title of certifier		29c 1	icense number	20d Date	signed (Mosth Day Vers)

	,			
29b.	Signature	and	title of	certifier
		1	20	

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

person who completed cause of death (Item 23a) (Type, Print)

University of Maryland School of Medicine Dept. of Medicine 22 South GREENE STREET

18 32 Registrate Street

State Registrar

5

31. Date filed (Month, Day, Year)

32. Registrar's Signature

within 24 hours after death To the Funeral Director:

MARION MCISON Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

			Pleas	se Type or Pri	nt in B	lack	Indelib	e Ink.	Ensur	e All	Copies	Are	Legi	ble.	
		For		State of M	aryland		•			nd M	ental Hyg	giene	on c	0.7	H.ngl.
		- State Registrar	- (F'- + A.E' L !!-		<u> </u>	- 1	Certifica	te of I	Death		2. Date of Dea	Reg. No	LU	U I	1 Time of Dooth
Physicia		1. Decedent's Name		1046LAS 1	Nac	NO					Month	Da		Year	3. Time of Death
/Medic Examin			, , _ ~	give street and number,	• •	011		, Town, or	r Location of I		April	24,		007 of Death	9:30 A ^M
Examin	er			shington N		tr	G1	en E	Burnie	е		7	Anne	arı	undel
Funeral		5. Social Security N		6. Sex 7. A 1 🔀 M 2 🗆 F	ge (In yrs. la		Months	r 1 Year Days		Hrs. Min.	8. Date of Birt (Month, Day	y, Year)		9. Birthp	lace (State or Foreign atry)
Director	}	235-30- Usual Residence of		1 4 2	81		rs.				01/23	/19	26		WV
yland now at		10a. State	10b. County		10c. City	, Town	or Location							1	0d. Inside City Limits
e Mar la-f sh tifled	ctor	MD	Anne	Arundel	Pas	sad	ena								1 ☐ Yes 2 X No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Nur						ip Code						What Cour	ntry?
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ours a	by	3 Widowed		If Yes, Give Year or Dates:	194		1 ☐ Yes	2LXNo	Specify:				Specif	w: Wh:	ite
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lental rked c	To Be	Walter	Jacob	Mason					Lula	а В	elle H	Iand	у£		
shou and N s mai		19a. Informant's N	ame/Relationsh	ip (Type. Print)		19b.	Mailing Addres	s (Street	and Number	or Rura	l Route Numbe	er, City	or Town,	State, Zip	Code)
and 2 ealth n 27 I		Gloria		/ Wife							Pasade				
ges 1 If Itel or oth			☐Cremation	3 ☐Removal from State	<i>;</i>		Disposition (No. 1), crematory of		1		ate			- City or To	
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permi Depa Impo any Ir		21. Signature of Ft	undrai Service	icerisee											Home, PA 21122
	\exists	23a. Part 1. Enter t	the disease, or o	complications that cause	ed the death	n. Do n							CIIG	,	Approximate Interval Between
Physician		Immediate Cause disease or condition	(Final	only one cause on each	ine.	6	ARRY	57	_						Onset and Death
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The law requires that the death certificate be ate has been signed by the attending physicia bage 2 should be detached for use as the bur	Physician/Medical	IF FEMALE:										T			
ath ce	ian/l	23b. Was deceden		23c. If yes, outcom	2 🗆 Fetal	death	3 □Ectopic		y					ite of delive	ery Day Year
the de	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4□Pregnant : 9□Unknown	at time of de	eatn	5 ☐ Other (specity) <u> </u>							
that the property of the prope		Part II. Other signi	ficant conditio	ns contributing to death	but not resu	ılting in	the underlying	cause giv	en in Part I.		23e. Did to	obacco	use con	tribute to the	ne cause of death?
quires	Completed by	COLOH	CAHO	(F)K							10	Yes 2	No.	3 ☐ Prob	oably 4 □Unknown
e law re has bee	plet	YROST.	ATE (CAHUER							24a. Was		24b.		psy findings available mpletion of cause of
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Attending Physician: r death. ector: After this certifica by the funeral director;	- To	1 ☐ Yes 2	·	28a. Date of In	iury	ER/Out 28b. T	patient 3x1	28c. Injur Wor	4 ∐ Nurs		ne 5 ☐ Resi 28d. Describe I				(y)
nding th. :: Afte e fune	tion	1 Natural 2 ☐ Accident	5 Pending investig	ation (Month, D	ay Year)	Ir	njury M		rƙ? Yes 2∐ No			•			
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To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)		g Physician: To the bes Examiner: On the basis and manners	of examinat										
o the other of the omple	Mec	29b. Signature and	d title of certifier		Naico:	1	2	9c. Licens	se number			29d. Da	ate signe	ed (Month,	Day, Year)
->		Bu		2 Man	whi	W	W	DA	1171			Ч	125	F0/6	-
かけ		30. Name and add	1 20	who com leved cause of	death (Item	23a) (Type, Print)	anz ki	Doive	, (JEHBY	1211;	1 X	W.	2/0/1
Sta Registr		31. Date filed (Mor			trar's Signa	-	A STATE OF THE STA	3				. 1 (. ر.	⊘ 1. ∧1
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 04/30/2007 Katherine Virginia Misek 12:30 DМ 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Towson Gilchrist Care Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/12/1932 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1 ☐ M 2 🗓 F Maryland 75 217-30-2573 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Anne Arundel Glen Burnie 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21060 U.S.A. 1120 Sunny Brook Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Store Cashier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Gaitlev Marie J. Brandt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1120 Sunny Brook Dr. Glen Burnie, MD 21060 Cindy Milligan, Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/03/2007 Gardens of Faith Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc. alexandrias osted of 5305 Harford Rd. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Emply Scine years Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPIQ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🔁 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

Examiner certificate be executed Box 68760, Division or Vital Records, P.O. Hospital or Attending Physician:

completely filled in by the funeral director, within 24 hours after death To the Funeral Director: 10

Physician

/Medical

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Director

Funeral

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Physician/Medical

Completed page 2 should

Be

Certification: To

Medical

29a. Certifier

MD

Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

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attending physician for use as the buna

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certificate

After this

Baltimore, Maryland 21215-0036

death with the Maryland

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and tess of person who completed cause of death (Item 23a) (Type, Print)

HALVES MO

and manner stated.

Charles St DWSON MD 21204

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician Vera F. Macciocca 30 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Mare Losedal imone Franklin If Under 1 Year | If Under 24 Hrs. 7. Age (In yis. last birthday) 9. Birthplace (State or Foreign Sex Social Security Number **Funeral** Days Min Months Hours 1998 94925 Maryrand 1 □ M 2 ☑ F 82 219-16-6108 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 □Yes 2□No Director MD Baltimore Perry Hall 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21128 9505 Kingscroft Ave. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 □ Yes 2 No Specify ģ 3₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Ziemba Peter Krol ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1217 Evsham Ave. Baltimore, Maryland Barbara Barocca / Daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place; Stanislaus Cem St. 5/4/2007 Baltimore, Marvland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Maryland 21214 5305 Harford Road Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final onic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine s been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 s autopsy performe 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Medical Certification: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 1 Natural Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After s after dea... ral Director; Aftr 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 30. Name and address of persor ath (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Registrar

State of Maryland / Department of Health and Mental Hygiené 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** HAROUD APRIL 2007 6:20 PM MILLER 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1701 Melbourne Road Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1**☑** M 2□ F 216-24-2216 Yrs. Director 79 March 14,1928 West Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "neturel", or Items 23a or 28a-f show The Medical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Maryland Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1701 Melbourne Road 21222 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes - 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done du life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Tow Motor Operator Continental Can Co. .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If item 27 is marked other t jury or other traumatic event, IL 9 Years 17. Father's Name (First, Middle, Last) other Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) Be Andrew Miller Florence Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Catherine Miller (Wife) 1701 Melbourne Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 4/28/2007 Rosedale, MD 21. Signatura of uneral Service L 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximation of the disease of the death of the The Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RESPIRATORY FAILURE 6 WEEKS /Medical Due to (or as a consequence of) Examiner CHRONIC DESTRUCTIVE PULMONARY DISENSE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-transit Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Be Completed by Physician/MedIcal esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ģ Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a o 9 Unknown 9 Unknown ۵, Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, been signe should be 1 Probably 4 Unknown CONGESTIVE HEART FAILURE CORDNARY ARTERY DISEKE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an FIBRILLATION ATRIAL autopsy performed 2 No 1 🗆 Yes 2 🗆 No 1 Yes of Vital After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Division or Attending 5 Pending investigation 1 Natural after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aft To the Funeral Di 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Func 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number D62032 APRIL 30. Name and address of person who completed Pause of death (Item 23a) (Type, Print) HAY15H BALTIMORE MO ZIZZE 5005 HOPKINS BAYVIEN CIRCLE JENNIFER 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 04 Physician Sister Mary Ellen Powell 4:10a M 2007 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 4100 Maple Avenue Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Yrs 216 54 0221 85 Virginia Director August 1,1921 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show the Medical Exempler must be notified at Maryland Baltimore Baltimore 1 ☐ Yes 2K No Directo 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? or items 23a or 4100 Maple Avenue 21227 U.S.A. deeth Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ∐Yes 2 [v] No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛣 No Specify: þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) other than Elementary/Secondary (0-12) Administration Religious Sister years permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic avant, 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eustace Conway Powell Mary Imogen Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Mary Becker 4100 Maple Avenue Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cem. 5/2/2007 * 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature Funeral Serve Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Part1. Soler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Se PSIS **Physician** /Medical Examiner 10x17 5 Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or us a consequence of): Hospitel or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stell price to the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sorid its 1 Yes 3 Probably 4 Unknown 24e. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No sease autopsy 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) P 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel of within 24 hours an To the Funeral Completely filled in 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated Herrita 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and SICIA 0 who completed cause of death (Item 2, a) (Type, Print) 20 Goarts. Registrar's Signature Date liled (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend #17,18, perFH, g867, 5/11/07 TT Certificate of Death

Rea. No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear **Physician** 18.35 M 30 APR 2007 John Joseph Pawlus, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Agnes Paltimore HOSpital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6 Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 XM 2 □ F Yrs. 5/26/26 New Jersey Director 147-20-4533 80 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD **Baltimore** Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 USA 715 Maiden Choice Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ⊠Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify ģ 3 Widowed 4 ☐ Divorced White WW II Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal 0 Contractor 17. Father's Name (First, Middle, Last)
Jozef Pawlus 18. Mother's Name (First, priddle Mailles Surname) Be Walter J. Pawlus Frances Polguy ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum 11 Lake Lacoma Drive Pittsford, New York 14534 Mr. Frank Chadwick / Son-In-Law 20b. Place of Disposition (Name of Baltinore a Crematory Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 5/2/07 @ Loudon Park 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave. Baltimore, Maryland 21229 ant 23a. Part 1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or in art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Pancreatitis Days /Medical Due to (or as a consequence of): Examiner Days SEPSIS Sequentially list conditions, Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events death certificate be executed attending physician and for use as the burial-transit Days ASCENDING CHOLANGITIS resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Pneumonia Days Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Depatient 1 TYes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Whatural 28c. Injury at Work? (Month, Day Year) Injury 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier K Rameth MD 17602 APR 30 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900S CATONS AVE, BALTIMORE, MD 21229 RAMESH KOLLT 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Charles Lee Reeves April 26 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Manor Care Rossville Rosedale Baltimore County 8. Date of Birth (Month, Day, Year) June 27, 1 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 1XXM 2□ F 7. Age (In yrs. last birthday) **Funeral** 83 216-18-9470 1923 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a, State show the Medical Examiner must be notified Director Maryland Baltimore County Rosedale items 23a or 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21237 United States 6600 Ridge Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↑ XYes 2 □ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0036 'natural', or Specify: 2 3X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Goetze's Caramel Cream than Elementary/Secondary (0-12) College (1-4or 5+) Mechanic 8 N/A i 2 should be filed w h and Mental Hygier is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Jenny Snowden Charles E. Reeves 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5013 Dorothy Field Road Perry Hall, Maryland 21128 Mr. Charles William Reeves (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 7 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 28/07 Forest Hill, Maryland Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Peaceful Alternatives Funeral&Cremation Ctr.,P.A 2325 York Road, Timonium, Marvland 21093 22. Name and Address of Facility 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIOVACCULAR THEROSULEROTIC Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Sequentially list conditions, If any, leauning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of a Examine sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the nse 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. ed by the a 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, δ 1 ☐ Yes 2 □ No Completed autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. spital or Attend tours after death. 2 Accident

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2X No

Maryland

2007

Black, White, etc.

3 Probably

death? 1 ☐ Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

APRIL 27, 2007

24b. Were autopsy findings available prior to completion of cause of

2 No

Specify: White

7:25 A.M

3+1

124 hours at ne Funeral C Hospital

within 2 the

> State Registrar

Medical

31. Date filed (Month, Day, Year)

2007

30. Name and address of person who co

MAY 02

6 □ Could not be

determined

3 ☐ Suicide

29a. Certifier

29b. \$ignatur

4 ☐ Homicide

201, BACIL RIVER NEUL RD. #109, BALTIMORE, MP 32. Registrar's Signature

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

of death (Item 23a) (Type, Print)

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

0060560

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Edith 30, 12:20 A^M Reisser April 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Co. Genesis Heritage Nursing Home Dundalk If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 2 K 3 K Yrs. 94 Nov. 6, 1912 Pennsylvania 179-10-5771 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Dunda1k Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1700 Evergreen Drive 21222 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: Specify. 3€ Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 10 Years <u>Homemaker</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Polatar Fannie Boka 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1700 Evergreen Drive Dundalk, Maryland Normandie F. Paciocco (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Sacred Ht. of Jesus Cem. 5/3/2007 4 ☐ Donation 5 Other (Specify) Dundalk, Maryland 21. Signature of F eral Service Licens 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ONGESTIVE disease or condition resulting in death) Due to (or as a consequence of): ORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): PULMORIARY DISEASE IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Worknown

Physician /Medical Examiner

permit. Pages 1 and 2 s Department of Health ar Important; if Item 27 is any Injury or other trau

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

2

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ant; If Item 27 is marked other than "natural", or Items 23a or 28a-f show ant; Item Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examine burial-trar the nse ō

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

attending

Division or Vital Records, P.O. Box 68760,

Physician/Medical Completed by Be Medical Certification: To

signed by the a s certificate has be irector, page 2 s this s after death.

I Director: After this of in by the funeral d within 24 hours aft

To the Funeral DI

completely filled in

State Registrar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ⋈ No 24a. Was an autopsy performed 20 25. Was case referred to predical examiner? 26. Place of Death (Check only one) Other: 4 Jurising Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier a ralle 29c. License number

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

0

29a. Certifier

(Check only one)

32. Registrar's Signatures Place & Clerchalle MB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1647 M 07 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 700 W.404. FIMORE MI n/a If Under 1 Year | ff Under 24 Hrs. | g. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 6. Sex 9. Birthplace (State or Foreign **Funeral** Year 1 M 2 F Months Days Min 83 Yrs. Maryland Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ul Hygiene. other then "natural", or items 23a or 28a-f show vent, the Mudical Examinat must be notified at 1∰Yes 2 No MD **Funeral Director** Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12261 Roundwood Road # 1208 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No WW II If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Completed by 3 Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Assistant Vice President Mercantile Safe & Trust 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill timent of Heelth and Mental H tent: If Item 27 is marked oth jury or other traumatic even Be Vaclav Svehla Stransky Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Clara Svehla (wife) 12261 Roundwood Road # 1208 Timonium, MD 21093 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If eny injury or one. 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Svc. Corp. 05/01/2007 Towson, Maryland 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10 /Medical Examiner 05 Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, physicien Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of defivery 2 Fetal death 3 Ectopic pregnancy ó in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Division of Vital Records, P.O. the (page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by D: whethe 3 Probably 4 Unknown 1 Yes 2 No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed this certificete 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Pface of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 N Certification; To 1 Tyes 2 ER/Outpatient 3 DOA After thi 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred 1 Listural 5 Pending investigation death. 1 🗌 Yes 2 🗆 No 2 Accident within 24 hours after death To the Funerel Director: , completely filled in by the t 6 Could not be 3 Suicide Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00009189 0 20+1 address of person who completed cause of death (ftem 23a) (Type, Print) 707

DHMH 17 Rev 1/2001

State

Registrar

apro

2007

MAY 0

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 2:10AM -LURENCE BERNICE SHERMAN 04 28 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WILLIAMSPORT WASHINGTON HUMEWOOD RETIREMENT CENTER If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2√F Director 216-22-2435 07/19/1925 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he maritand as 10c. City, Town or Location 10h County 10d Inside City Limits 1 ☐ Yes 2 ☐ No Director Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16729 Buford Drive 21795 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by Specify: Specify: White 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be Samuel I. Cochran Nettie Lyzear 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Sherman 16729 Buford Drive, Williamsport, MD 21795 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 05/3/2007 Elkridge, MD 21. Signature of Funeral Service Licensee Gary L. Kaufman Funeral Home at MMP, 7250 Washington Blvd., Elkridge, MD M01378 236 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Preymonio /Medical Due to (or as a consequence of): Examiner Sendo monas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident (Month, Day Year) 5 Pending investigation i after death.

i Director: A
d in by the fu 1 🗌 Yes 2 No 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 ☐ Homicide within 24 hours a To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 047234 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13424 STRAUSS PENNSYL YANIA AVENUE 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 200^{Year} Day **Physician** 27, 9:20 Рм Patricia C. Scott /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Timonium Baltimore Stella Maris If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar. 19, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Hours ^{Year)} 1919 1 🗌 M 019-18-4170 88 Mar. New York Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 3a or 28a-f show t be notified at 10a. State 10b. County 1 ☐Yes 2 ☐XNo Director Lutherville MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examinar must by once. 21093 USA 107 Ardoon Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White 9 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise Brigham John Crawford ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas G. Scott 107 Ardoon Road; Lutherville, MD 21093 son 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans 5/4/07 Owings Mills, MD 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home 23a. Part1. Enter the disease, or complications I at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one car/y on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 📉 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 has perform certificate 2**X** No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.

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filled in by the funeral dire 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined

within 24 hours a To the Funeral I

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Medical

PATRICIA SCOTT

27,

Registrar DHMH 17 Rev 1/2001

State

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only onel

29b. Signature and tile of certifie

31. Date filed (Month, Day, Year)

TARIQ MAHMOOD

MAY 02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

TIMONIUM, MD 21093

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2300 DULANEY VALLEY RD.

32. Resistrar's Signature

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 30 0

Physic /Medi		Dennis Le	e (First, Middle, L Se Spille	ast) Brs							2. Date of D Month April	Day Day	2007	Year	3. Time of Death 5:30 Am
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-f show lied at	tor	Usual Residence of 10a. State MD	10b. County Montgom	ery		City, Town or Lo	ocation								10d. Inside City Limits
23a or 28a si be noti	Funeral Director	10e. Street and Nur 3900 Cher	nber ry Valle	y Dr.			10f. Zip 208					10g. Citi	zen of W		•
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 22 2007 Robert Ervin Seals 11:53 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Prince George If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Days 1**X**M 2□ 458-66-4582 66 August5,1940Mississi ppi Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Prince Georges Hyattsville MD Director with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20783 USA 1801 Metzerott Road death Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examine TYYes 2 No f Yes, Give 1 Never Married 2 Married 1 □ Yes 2 ☑ No Specify. Baltimore, Maryland 21215-0036 SpecifyBlack þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Elevator Engineer 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearlie Mae White James Anderson Seals 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2000 Buoy Drive Stafford VA Beverly Annette Seals; 22554 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/02/07 Clinton MD Ressurection Cem. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 20019 DC Dunn & Sons 5635 Eads Street NE Washington Approximate Interval Between Onset and Death 23a. Art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or a a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the 9□Unknown 9 Unknown I signed by t. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 XNo 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1∐ Yes 2⊠No page 2 1 Yes 2□ No certificate 80 ma or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No 1 📉 Inpatient မ After this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural To the nospinal within 24 hours after death. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and t 45660 1 30. Name and address of person who completed cause of death (the n 23a) (Type, Print) CO ex (2)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 02

2007

2. Registrar's Signature

07-03225 Dewitt A. Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certificate designed by Incertal Director: After this certificate has been signed by the attending lely filled in by the funeral director, page 2 should be detached for use as	by P	Part II. Other significant condi	tions contributing	to death but n	ot resulting	g in the un	derlying cause	given in Pa	art I.			use contri	_		
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of Vital Records, g Physician: The law require the christicate has been sineral director, page 2 should b	Completed									1 ✔ Ye	s 2 1		✓ Yes	2	No
ician: s certit	Be	25. Was case referred to medica examiner?	Hospital: 1	l				Other	-		7		7		
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On C ath. r: Af	tion	1 Natural 5 Pen	ding Apr 27	th Day Year) , 2007	- 1	4 hrs	· ·] · ·	Yes 2 ✓		Subject st		,,			
Division tal or Attendi rs after death. al Director: A	fica		estigation 28e. Pla	ice of Injury - /	At home, fa	arm, street	, factory, office	building, e	tc. 2			and Numbe	er or Rura	Route N	umber, City
Divinital o	Certification:			Street					1	or Town 600 N. Ro	, State) sedale :	Street, Ba	Itimore,	Md	
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A	Medical (hysician: To the beaminer:On the basis	of examination											
F. S F. S	Me	29b. Signature and title of certific	and manner er	Stateu.			29c. Licen	se number	_		29d.	. Date signe	ed (Month	ı, Day, Ye	ar)
1		* 1/	1/1	_			0.0	.M.E.			Ap	ril 28, 20	07		
5		30. Name and address of person			,										
		Mary G. Ripple MD. 31. Date filed (Month, Day, Year)	Deputy Chief	Medical E		r 111	Penn Stree	t, Baltim	ore, MI	21201					
Si Regis	ate trar	MAY 0	2 2007	Anglottal S Old	A.	Som	Se D								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** SHAW 7:30p M MAE -11415 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** GEN BYRNIE 7637 ARINDEL SPENCER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. 1 (Month Day Year) SOUTH CAROLINA 1 □ M 2 🕁 F 84 Yrs. 216-22-4559 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 TYYes 2 □ No **Funeral Director** ANNE ARUNDEL GLEN BURNIE MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA. 7637 SPENCER RD 21060 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married BLACK 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
7 is marked other than "natul traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPING DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 GRACE HAMILTON ARTHUR THOMPSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WAYNE DAYIS (NEPHEW) 8307 BANISTER RD. SEVERN, MARYLAND 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Crematic 3 Removal from State Ther (Specify) METRO CREMATORY 5-1-2007 BALTIMORE, MARYLAND 21. Signature of Funeral Service Ligensee JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shocks or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Covonary Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 0000 Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events are ultimated events) Examiner Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buris Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 1 ☐ Yes 2 No ို 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

1600 CRAIN

Registrar's Signature

SUITE 206,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAY 0 2 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 4 Mildred Albina Sheehan 28 2007 12:55 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4 / 3 / 1922 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Months 1 □ M 2 🔀 F 85 213-20-5069 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the M circal Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2√ No Director MD Baltimore Middle River 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 824 Seneca Park Rd. 21220 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: 3X Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hochschild-Kohn 12 Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John S. Jeskiewicz Gertrude Stawikowska ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21220 19a. Informant's Name/Relationship (Type. Print) Raymond Piechocki/nephew 824 Seneca Park Rd. Middle River, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens Date 20a. Method of Disposition 20c. Location - City or Town, State May 1, 2007 ₩Burial 2 ☐Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 22. Name and Address of Facility
Evans Funeral Chapel
Cremation Services Funeral Service Licens 8800 Harford Parkville, MD Cremation Services a. / art1. Enter the disease, or co. / cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or irrary Due to (or as a consequence of): Examiner that initiated events resulting in death) Last as the bunal-tran Due to (or as a consequence of): attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 📉 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown יוא כיווווכם e has feen signed by director, p. ge 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: ${}_{4}\square$ Nursing Home ${}_{5}\square$ Residence ${}_{6}\mathbf{X}$ Other (Specify) **HOSPICE** 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 2300 DULANEY VALLEY RD. DR. TARIQ MAHMOOD TIMONIUM, MD 21093 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 02 2007

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State Registrar

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BALTIMORE MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREN DORSCH MID

31. Date filed (Month, Day, Year)

UMMC

32. Registrar's Signature

DIANA SHORT Baltimore, Maryland 21215-0036

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n or Vital Records, P.O. Box 68760, ~	ng Physician: The law requires that the death certificate be executed	fler this certificate has been signed by the aftending physician and ineral director, page 2 should be detached for use as the burial-transit
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Physic	ian	Decedent's Name (First, Middle, Last)	Diana	S	hort		2. Date of Deat Month	th Day Year	3. Time of Death 7. 6:55PM
/Medi } Exami		4a. Facility Name (If not institution, give street		DITOI		r Location of Death	APRIL	28 200- 4c. County of Dea	
Funeral	9	GOOD SAMARITE 5. Social Security Number 6. Sex		PITAL yrs. last birthday)	If Under 1 Year	TIMORE	8. Date of Birth	N/A 9. Bir	thplace (State or Foreign
Director		189-10-7464 Usual Residence of Decedent		Yrs.	Months Days	Hours Min.	(Month, Day) July 1	, Year) Co	ountry) ennsylvania
tryland show	_	10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the Ma 28a-fs	Director	Maryland Baltimo	re	Mi	ddle Rive	er	1	0g. Citizen of What Co	
ath with 5 23a on uust be	ralD	809 Bowleys Quart					1220	United S	
after dea or items niner m	Funeral	1 ☐ Never Married 2 ☐ Married	Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No	1		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
ite, INIAI yially ZIZIO-000 stand 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify: 16b. Kind of Business	White
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ifiled will Hygier other the		8 Years 17. Father's Name (First, Middle, Last)	.	HC	memaker	18. Mother's Name	e (First, Middle, I	Own H Maiden Surname)	lome
yiall ould be Mental arked o	To Be	Simo Vignovich					Vignjev		
INCL YICH TO THE INCLUDE THE INCLUDE WITHIN THE WITHIN THE INCLUDE		19a. Informant's Name/Relationship (Type. Michael Ivkovich	Print) (Son)		ng Address <i>(Street</i> .1 Bay Dr:			r, City or Town, State, [aryland 2	Zip Code) 21220
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo		0b. Place of Dispo cemetery, cre	osition (Name of ematory or other pla	ce)		20c. Location - City or	
mit. Pa bartmer sortant: rinjury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	000		Cemeter	es of Facility		Baltimore,	_
Departiment of the concession		23a. Part1. Enter the disease, or complicati	_all		7922 Wise	Ave. Du	ndalk Ma	Dundalk,In	The state of the s
Physician		shock, or heart failure. List only one commediate Cause (Final disease or condition	ause on each line.	PREA	_	ARCINO			Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a cor	7. The second se		ING	CANO		
70 #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence of):		3146	CHIVE	EK	
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ficate be e physician ts the burk		_d							
the aftending physician and hed for use as the burial-transit	Physician/Medica	23b. Was decedent pregnant	If yes, outcome pf pr 1□Live birth 2□		⊒Ectopic pregnanc	y		23d. Date of de	elivery Day Year
the dea	nysici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specify)			WIOTH	Day real
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nysicial nysicial nis certii directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hos	pital: Inpatient	2 ER/Outpatie	nt 3 DOA Oth	26. Place of Deat ner: 4 ☐ Nursing Ho		ence 6 □Other (Spe	ecify)
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the aftending physicial completely filled in by the funeral director, page 2 should be detached for use as the burn	Certification:	- □ - · · · C □ Could not be ⊢	28e. Place of injury - building, etc. (S	At home, farm, st pecify)	reet, factory, office		28f. Location (S City or Town	treet and Number or Fi n, State)	Pural Route Number,
ie Hospita 124 hours ie Funera pletely fille	Medical (29a. Certifier (Check only one) Check only one) Certifying Physici 2 Medical Examiner							
To the within to the complex c	M	29b. Signature and title of certifier RENU	GUPTA	, M. I	29c. Licens	S 000		29d. Date signed (Mon	ith, Day, Year) 2007
6		DR RENU GUPTA	leted cause of death	SAMA F	ZITAN V	HOSPITAL	BALT	IMORÉ,	MD
St Regis	ate trar	31. Date filed (Month, Day, Year) MAY 0 2 2	32. Registrar's S	Signature	Carle				
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State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 0 7 4										
			Decedent's Name (First, Middle, Last)		. Date of Death	3. Time of Death				
	Physici		Judson Sp	29000	April 25 2007	10:30 PM				
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death					
1	Exami		Johns Hoskins Daywew Care Center	er sollinore	Bothm	ore City				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bit		. Date of Birth 9. Birthp (Month, Day, Year) Cour	lace (State or Foreign				
	Director		220-24-4304 XM 2 F 80			Carolina				
	р "		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Tow	m or Location	1	Od. Inside City Limits				
	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It am American 23a or 28e-f show traumatic event, the Madical Examiner must be nutified at	_	10a. State 10b. County 10c. City, Tow	n or Location	· ·	1 Yes 2 No				
		Director	Maryland Baltimore	Baltimore 10f. Zip Code	10g. Citizen of What Cour					
			7614 Riddle Avenue			407				
	eath	Funerai	11. Marital Status 12. Was Decedent Ever in U.S.	21.224	fy Yes or No. 14. Race - Americ					
	ther d	F	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	13. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri	can, etc.) Black, White,	etc.				
936	ol', ol	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify:	White				
21215-0036	2 ho	Completed		Decedent's Usual Occupation	16b. Kind of Business/Inc	dustry				
215	within 7. ene. than "n	ble	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)						
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yla	should be ind Mental s marked o umatic eve	Tol	James Douglas Spencer		M. Wright					
Maryland	2 should be and Mental is marked (b. Mailing Address (Street and Number or Rural I						
	C = 40 F		nveryn nyero			21.224				
OLE	S		20a. Method of Disposition 1∑ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of cemete	of Disposition (Name of Daily, crematory or other place)						
Ē	nit. Pag artment ortent: Injury e				/2007 Baltimore,	Maryland				
Baltimore,	permit. Page Department o Importent: If any Injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Duda-Ruck Funeral H 7922 Wise Ave. Du	ome of Dundalk, In	nc 222				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approxim							
12	Pnysician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition							
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			Sequentially list conditions, b. Respiratory Failure on Machanial 4							
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876	ate the	dicai	d							
9	leath certifica attending ph I for use as tl	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy							
Вох	ath c	Physician/Me	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delive Month	Day Year				
0	ires that the c signed by the d be detached	ysic	1 Yes 2 No 4 Pregnant at time of death 9 Unknown							
Ω.			Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to the	ne cause of death?				
ds,		d b	1 standard Stall stand	1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unkr						
Ö	w requ been shouk	Completed by	3/)	24a. Was an 24b. Were auto	psy findings available				
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V.	Physicien: this certific ral director,) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☑ Inpatient 2 ☐ ER/O	26. Place of Death (
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/isi	Attendi death. sctor: A	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, fi	arm, street, factory, office 28	8f. Location (Street and Number or Rural Route Number,					
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	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)							
	To the within ? To the comple	Med	29b. Signature and Mile of certifier	29c. License number	29d. Date signed (Month,	Day, Year)				
			NIS (Z M) D04383 Apr:126,2007							
	X	i	30. Name and address of person who control d cause of death (Item 2 la		earcigh					
	ט	5 505 Hapkins sayview Circle, Baltimore, Manylord 21234								
	Sta		31. Date filod (Month, Day, Year) 32. Registrar's Signature	Asorte)						
	Regist	rar	MAY 0 2 2007	1/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician SHOFER 27 RICHARD 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner MARY LAWS MES con.

7. Age (In yrs. last birthday)

Yrs. NIA UNIVERSITY BALTIMORE
If Under 1 Year | If Under 24 H CENT. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Director 06/21/1933 219-28-1068 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f sh notifled 1 ☐ Yes 2 No Director PA YORK **NEW FREEDOM** 10e. Street and Number 10g. Citizen of What Country? "natural", or Items 23a or idical Examiner must be r 557 LAKESIDE DRIVE 17349 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 🕻 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced ear or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER CROWN MOTORS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL SHOFER SARA COHEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health of item 27 I 557 LAKESIDE DRIVE, NEW FREEDOM, SARAH MCHALE / WIFE 20b. Place of Disposition (Name of Cemetery crematory or other place)
NEW FREEDOM
CEMETERY 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of P
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/01/2007 NEW FREEDOM, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPITORY ACUTE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day signed by the at d be detached for 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ KLEBSIELLA PNUEMONIA BILAT 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No ENDO CARDITIS 24a. Was an autopsy performed? Yes 2 No ACUTE RENAL 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 29b. Signature, and title of certifier 29d. Date signed (Month, Day, Year) DOUJJ 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HASDAY BALTIMORE M'S JEFFREY

Registrar

State

31. Date filed (Month, Day, Year)

MAY 0 2 2007

DHMH 17 Rev 1/2001

32. Registrar's Signature

			For State Registrar	State of Maryland		artment of H			jiene eg. No.	07	14105
			1. Decedent's Name (First, Middle, Las	st)	***************************************			2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic		Michael W	I. Tyson				Apri1			4:30 A M
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or			4c. Count		'alla
			2712 Howard Grove				dsonvil.			,	undel
	Funeral		5. Social Security Number 6. S	TM 2DE	ast birthday) Yrs.	Il Under 1 Year Months Oays	If Under 24 Hr Hours Min		Year) 1957	9. Birth	place (State or Foreign
	Director	-	227-82-8139 Usual Residence of Decedent	49	113.			Sept 29	, 1957		Korea
	land		10a. State 10b. County	10c. City	, Town or Lo	ocation				1	10d. Inside City Limits
	Mary	Ö	Maryland Anne An	runde1	Day	vidsonvil	1e				1 ☐ Yes 2√☐ No
	288	Director	10e. Street and Number 10f. Zip Code						10g. Citizen of	What Cou	ntry?
	3a ol		2712 Howard Grove Road			21035			United	l Sta	tes
	death death	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.			(Specify Yes or No- erto Rican, etc.)	14. Ra		can Indian,
9	or its	T	1 □XNever Married 2 □ Married	1 ☐ Yes 2 █️XNo If Yes, Give			Specify:	ano mican, etc.)		ick, White,	
8	rai'.	d by	3 Widowed 4 Divorced	Year or Dates:			Spoony.		Speci	·y.	Whtie
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or iteme 23e or 28e-f ehow ta Mudical Exemitive r unal be notified at	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occup	during most of w	rorking	16b. Kind of B	Business/Ir	ndustry
2	hen.	du	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	"		Const	truct	ion
7	iled v dygie ther t		12th 17. Father's Name (First, Middle, Last))	Ca	rpenter	18 Mother's N	ame (First, Middle,			1011
and	ntal h	Be					Jung		ee		
Ž	hould d Me mark mark	Ţ.	Joseph Arthur 19a. Informant's Name/Relationship (Tyson, Sr.	19h Maili	ng Address (Street		Rural Route Numbe		State 7ii	n Code)
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if item 27 is marked other then "natural", or iteme 23s or 28e-f show with injury or other traumatic event, the Maddical Exprinter out he notified at ADGE.		Jung Ok Tyson/mo	Plemoval from State West	lace of Dispo emetery, cred L Arun	osition (Name of matory or other placed del Crema	e) itory 5/	Date	20c. Location Odente	City or Ton, M	ary1and
<u> </u>	9 Q F # 9		Quanta 024	nomao	1	411 Annap	olis Ro	ad Odent	on, Mar	rýĺan	d 21113
8760, 4	signed by the attending physicien and signed by the attending physicien and deflace as the burial-transit	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
.O. Box 687		by Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 22 No 9 Unknown U							23d. Oate ol delivery Month Day Year	
<u>α</u>	that the solution of the solut	무	Part II. Other significant conditions of	contributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use cor	tribute to t	the cause of death?
ds,	sign ed b		,,,			, ,		1 □ Y	es 20 No	3 ☐ Prol	bably 4 □Unknown
Ö	w requir been si should	ete	Oto Mina						24. 14.		
Vital Records,	i: The law requires that the icete has been signed by the r, page 2 should be detache	Completed						24a. Was a autop: perfor	sy	prior to co death? 1 \(\text{Yes} \)	opsy findings available ompletion of cause of
₹	sicia: certii recto) Be	25. Was case relerred to medical examiner?	Hospital:		at all post Oth	ar	eath (Check only or			
ō	Phys rthis raldi	: To	1 ☐ Yes 2 ☑ No 27. Mannes of Death	1 ☐ Inpatient 2 ☐ 28a. Oate of Injury	28b. Time of	II 3 DOA	4 🗀 Nursing	Home 5112 Hesid	ence 6 ⊡Ot ow injury occu		fy)
o	ding h. Aftel fune	tlon	1 ☑Natural 5 ☐ Pending	(Month, Day Year) Injury Work?							
Division of	To the Hospitel or Attending Physician: The lawithin 24 hours after death. To the Funerel Director: After this certificete has completely filled in by the funeral director, page 2	Certification:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospitel within 24 hours a To the Funeral completely filled	Medical (29a. Certifier Check only one) Certifying Pt 2 Medical Exer	Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ceminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					stated. to the cause(s)		
	29b. Signature and title of certifier 29c. License number							29d. Date signed (Month, Day, Year)			
			Atta HIM	Elmu A		N08	5110		MONIC	36	2005. R
	ί)	Tark!	30. Name and address of person who STANLRY WAS	completed cause of death (Item	23a) (Type,	Print) BYGATE	Pp 0	Annon	10215	420	21401
	Sta Registi	-	31. Oate filed (Month, Day, Year)	32. Registrar's Signa	ture	leget !					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2 45 p M LIN DSAY D. TAYLOR, SI 29 07 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALMMERE PERKING PARKUILLE RAMICUM CrENESis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**⊠**M 2□ F 88 Director 212-03-5204 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic avent, the Medical Exementary ust be notified at 1 ☐ Yes 2 No Baltimore Middle Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code USA or Itams 23a 4021 alaao 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White 3 Widowed 4 Divorced 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) ACCOUNTANT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Llouis Henry 12×101 Marshal 19a. Informant's Name/Relationship (Type, rint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd. Middle RIVER, MU of Health : POINT 4021 Briar jorothy aylor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page:
Department o
Important: If any injury or once. Tay 3, 2007 Sykesville, MD County Cremoition! 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher, FUNERal Home, P.A. 21. Signature of Funeral Service Licensee 254 East St., Westminster, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BLADDEL CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Certification; To Be Completed by Physician/Medical Examiner Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4 Pregnant at time of death 5 Other (specify) of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Dim page 2 autopsy performed 2 No 1 Tyes To the Hospital or Attanding Physician: filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 4√0 2 ER/Outpatient 3 DOA 4 Narsing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 Tyes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours. 12-Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 5/1/07 1) 31 >95 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSEN 166552 6701 H CHANCES SUITE 200 WENDY 4202 31. Date filed (Month, Day, Year) MAY 0 2 2007 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Thomas 2007 9:30P M Mary Margaret April 28,_ /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Co. Franklin Woods Nursing Home Rosedale If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Months 1 M 2 3 Director 83 Feb. 14,1924 Maryland 216-18-1622 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2/5 No Director Baltimore Middle River Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 1301 Washington Irving Lane United States 21220 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. e filed within 72 hours after all Hygiene. I **other than "natural", or Ite**l 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland School for College (1-4or 5+) Elementary/Secondary (0-12) the Blind Cafeteria Worker 11 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental F Pages 1 and 2 should be Virginia E. Duckworth Lee Shaffer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If Item 27 is any Injury or other trau 203 Prescott Court Havre de Grace, Maryland 21078 John Thomas Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ₭ Burial 2 Cremation 3 Removal from State Middle River, MD Holly Hill Mem. Gdns. 5/2/2007 4 □ Donation 5 □ Other (Specify) Structure of Funeral Service Licensee Name and Address of Facility 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiac Physician /Medical Due to (or as a consequence of) **Examiner** neart itive OM if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, physician a the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. | signed by the a 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate | 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

in 24 hours after control the Funeral Director: Af within 24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gan-Carden Frankl MD 105

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

0

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April June Adrienne White **Physician** 16, 2007 9:25 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Larkin Chase Nursing Facility Prince Georges Bowie If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖫 F Months Days 193-20-9654 12/1925 Washington, DC Director Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State ral', or Itama 23a or 28e-f show Examiner must be notified at Durham Carolina Bourham NC 1XYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4415 Myers Park Drive 27705 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. Specify: Black by 3 X Widowed 4 Divorced "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Nurse Assistant Starr Nursing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be and Mental Is marked Elsie Gardner Milton Perry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4415 Myers Park Dr. Durham, NC Mignon Turrentine/Daughter Health Item 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or oti 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/02/2007 Riverdale MD Riverdale Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 20019 Dunn & Sons 5635 Eads St. NE Wash, DC malla 23a. Pont. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death areliac **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🔀 No 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Q Onknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available pnor to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate After this certification, I Be 25. Was case referred to medical 26. Place of Death | Check only one) Other 1 Yes 2 No Certification: To 1 🗌 Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) Annapolis MD 240

Registrar DHMH 17 Rev 1/2001

State

31. Date file (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** 495 M NORMA 2007 4 30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore
Inder 1 Year | If Under 24 Hrs. Baltimore Cromwell Center - Genesis ElderCare 8. Date of Birth (Month, Day, Year) 01/11/1922 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🗶 F Pennsylvania 85 Director 179-14-0163 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show traumatic event, the M-dical Examiner must be notified at 1 ☐Yes 2 No Director Baltimore Perry Hall 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code ö 21128 U.S.A. 4516 E. Joppa Road items 23a Funeral . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amy Injury or other traumatic event, the Maonee. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Williams Cecil 2 William Haywald 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4516 E. Joppa Road - Perry Hall, Maryland 21128 Mark W. Weldy (son) Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 05/01/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 24401 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sartic Physician /Medical Due to (or a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,4少 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4/30/07 Lelle Lo Mus 8710 EMBE RO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

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DETGADO, CROMWELL CENTER

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12	[30. Name and address Susan Hoga		completed cause of sistant Medical		-	nn Street, Ba	Itimore M	1D 2120				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 25,2007 **Physician** April 3:15 AM BONNIE LEE WIMMER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F 82 408-34-8046 Oct. 27,1924 Tennessee Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Parkville MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3319 Woodside Avenue 21234 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify. Completed by 3 ☐Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Flossie Dykes James Dykes 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 94 Crooswind Drive-Shrewsbury, PA 17361 Frank Wimmer, Jr -son Pages 1 an nent of Healt. T: If item 27 y or other tr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens Of Faith Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Mg Burial 2 ☐ Cremation 4-28-07 3 ☐Removal from State Department o Important: If any Injury or Rosedale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility EVANS FUNERAL AND CREMATION 21. Signature of Funeral Service License 8800 Harford I Parkville,MD 21234 Road CHAPEL SERVICES 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ado. r 1 week /Medical Due to (or as a ronsequence of): Examiner de Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of): Examiner burial-transit Due to (or as a consequence of): physician a the burial Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed2 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

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Baltimore, Maryland 21215-0036

attending p ed by the a signed b peen has director, page 2 certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

Medical

State Registrar

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) nr: 625,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - Bruc

6701 A. Charles St. Balto . md 21204

31. Date filed (Month, Day, Year

4 Homicide

(Check only one)

29a. Certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 4:44 p M 2007 April 24 Daniel Walther, Jr /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1**X** M 2□ F 78 Dec. 8, 1928 Virginia Director 579-32-7667 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heatth and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Silver Spring Director MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 15115 Peach Orchard Road 20905 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 No Specify: White Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Master Electrician Walther Electric ĺ2th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy O'Bier Daniel Joseph Walther ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) .. Pages 1 and 15115 Peach Orchard Road, Silver Spring, MD Nancy Jean Walther/Wife Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any Injury or 4/30/2007 Mt. Olivet Cemetery Hanover, PA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility M01103 313 Talbott Avenue, Laurel, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C (Final disease or condition resulting in death) 5 dura Physician /Medical Due to (or as a consequence of): Examiner Vorn Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit er Due to (or as a consequence of) Physician/Medical Box IF FEMALE: 3 Ectopic projection 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 0 Month Year Day in the past 12 months? 1 ☐ Yes 2 No 4⊡Pregnant at time of death ed by the a detached f Ö 9☐Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b ş Records, pe 2 No 3 Probably 4 Unknown page 2 should Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred fell after funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 2.2 No 1 ☐ Yes 22/07 0430 M 5 K death. Hospital or Attendi 24 hours after death. Funeral Director: 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) | 5/15 | Local Or the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (9 and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 4 Homicide To the Hospital of within 24 hours af To the Funeral D 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 50113 ev 07

Registrar

DHMH 17 Rev 1/2001

State

Bethesda, Maryland

20814

8218 Wisconsin Avenue, Suite 403,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32/Registrar's Signature

Dr. James Robey,

MAY 0 2 2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Dorothy, Wroten 12:05AM 24th 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Harbor n/a 8. Date of Birth (Month, Day, Year) 08/26/1927 If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Days Hours Min. 1 □ M 2**X** F 218-22-5029 79 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important; If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 179 Meadow Road 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes W No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No ò Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Bozek Elsie Tzietko ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Ryder/Daughter 182 Kenwood Road, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Pk 04/30/07 Baltimore, MD 21. Signature of Eugeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or h art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pylmonary Disease Physician disease or condition resulting in death) Choric Obstructive MKNOWN /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of) attending physician Completed by Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9⊡Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Preumonia, congestive heart failure 1 Yes 2 No 3 Probably 4 Unknown Hypothyroidism 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manuer of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

the Hospital or Attending Physician; The law requires that the death certificate be execute Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dii

Baltimore, Maryland 21215-0036

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certifier evin Trice MD 29c. License number RES0001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hanover Street Baltimore, MO Price 3001 S.

31. Date filed (Month, Day, Year) 0 2007 MARIAS.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Sadie M. Walters 6:00 A.M April 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner. Glen Burnie Health & Rehab. Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗑 F Months 230 26 7302 78 Director May 17, 1928 Virginia Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23c or 28a-1 show any injury or other traumatic event, the Mudical Externing must be notified at once. Maryland Anne Arundel Director Baltimore 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 311 Cresswell Road 21225 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 KI No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) McCormick Spice Assembly Worker 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ola Coursey / Niece 7878 Mansion House Crossing Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 4/24/2007 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Oth'ar (Specify) 21. Signa Ne al Funeral Serv 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each complications that caused the death. Do not enter the mode of Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit ed by the attending physician and detached for use as the burial-tra-Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 month 1 Tes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by I contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 245. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica 25. Was ca referred to medical examiner? 26. Place Death (Check only one) Other: A Nursing Home Hospital 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 3: 30 PM 2 (No 1 Tyes 04-03-2007 2 Cocident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Home 311 CRESSWELL Rd BAITI MD 31225 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

Harjit Singh, M.D.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5410-A Ritchie Highway

Baltimore, Maryland 21225

31. Date filed (Month, Day, Year)

Registrar

			State of Marylar				lental Hygi	ene	7 11.115
			1 - State Registrar	Cei	rtificate of	Death ———		g. No U L	14 I J
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Y	3. Time of Death
	/Medic	al	Gertrude M. Wondra 4a. Facility Name (If not institution, give street and number)		4h City Town o	r Location of Death	04	30 20 4c. County of	007 07:30 a ^M
	Examin	er	Morningside House		Parkvill			Baltimo	
1501	Funeral	15	5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
	Director		214-18-6279 1□ M 2♥ F 91	Yrs.	Months Days	Hours Min.	11/08/19	915 G	ermany
	pur *		Usual Residence of Decedent 10a. State 10b. County 10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Aaryla f sho ed at	ō		**					1 ☐ Yes 2 💢 No
	the N 28a- notifi	Director	MD Baltimore Ba:	ltimore	10f. Zip Code		10	g. Citizen of Wha	at Country?
	3a or		9521 Hallhurst Road		21236			U.S.A.	
	deatl	Funeral	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp	ecify Yes or No-		American Indian, White, etc.
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ğ	S = 0		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State		matory or other place	i i			re, Maryland
Baltimore, Maryland 2121	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Licensee		Cemetery 2. Name and Addre		eonard J		*
ñ	Imp Deg		Olexandria Bates	5	305 Harf	ord Rd. B	altimore	, MD 212	214
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•	m		30. Name and address or person who completed cause of death (Ite	m 23a) (Type				3/1/00	0 1
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Marylar		rtificate of			leg. No.	7 4 6
	Physicia	an	1. Decedent's Name (First, Middle, La					2. Date of Dea Month April	28, 200	3. Time of Death 2:00 P M
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	Funeral Director		213-03-4809	Sex XXM 2□F 7. Age (In yrs. 95	last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb • 22	2 , 1912	9. Birthplace (State or Foreign Country) Maryland
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			1 - For State Registrar	State of M	Marylar		artmen			and M	-	giene Reg. No	007	14117
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	Physici /Medic		William Albert								April	20	2007	1530 P M
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172	Funeral	· -	Social Security Number 6. S	Sex 7.7	Age (In yrs.	last birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Birt			hplace (State or Foreign
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10	72 hours after death with the Maryland natural; or Items 23a or 28s-1 show dical Examination confilled at	Funeral Director	11. Marital Status 1 Never Married XXMarried	12. Was Deceder Armed Force: 1 XYes 2	5? T.N.o.		Was Deced If Yes, spec	lent of Hi offy Cuba	spanic Orig n, Mexican	gin? (Spe , Puerto P	cify Yes or No Rican, etc.)	1	I. Race - Ame Black, White	e, etc.
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19	be filed within 72 hours after death with the Marylan ital Hygiene. nd other than "natural", or Items 23a or 28a-f show event, ite Medical Ехапта и пила бель пилиед	Be Co	17. Father's Name (First, Middle, Last,)	·	1010	ilica 12		18. Mothe	r's Name	(First, Middle,			
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Maryland	nd 2 shulth and 27 is m		19a. Informant's Name/Relationship (Annette Boykin-Yo								Route Numbe Washing			
	the Hear		20a. Method of Disposition	ung	20b. F	Place of Dispo				Di	ate		ation - City or	
mo	Page: nent o int: if		1 ⊠Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		9	Linco				pri1	26,	Bren	twood,	Maryland
Baltimore,	permit. Pages 'Department of Himportant: If Ite any injury or of page.		21. Signature of Fundamental Serve Lio	a contract of the contract of	5						ert G. E, Wasl	Maso	n Fune	ral Home Inc
18	j.		23a. Part1. Enter the disease, or com shock, or heart failure. List only	ptications that caus one cause on each	ed the deat line.	th. Do not ent	er the mode	e of dying	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		tmmediate Cause (Finat disease or condition resulting in death)	a Jato	el C	ardy	re 6	Ver	4th	mia				Criser and Death
	Examiner		Due to (or as a consequence of): - Sequentially list conditions b. Hyputensum											
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		is a conseq	quence of):			/ .					
*	and I-trans	Examiner	Cause (Disease or initury that initiated events resulting in death) Last	c. Due to (or a	mar	y U	ellry	/ Y	Ull	ase				
68760,	ate be executed hysician and he burial-transit	caiE		d	(9,100 017.	U							
39	rtificate ng phy as the		is service	d										
Вох	death certifica e attending ph ed for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Feta	al death 3□	Ectopic pre	egnancy				23	d. Date of deli Month	very Day Year
P.O.	he dea	Physician/Med	1 Yes 2 No	4 ☐ Pregnant 9 ☐ Unknown	at time of d	leath 5□	Other (spe	ecify)					INICALLY	Day 16a1
	The law requires that the de sie has been signed by the a page 2 should be detached	by Ph	Part II. Other significant conditions of	ontributing to death	but not res	sutting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use	e contribute to	the cause of death?
ords	en sig										101	′es 2 🗆	No 3□Pro	obably 4 Honknown
ecc	a o o	Completed									24a. Was autop	SV	prior to d	topsy findings available completion of cause of
al H											1 Yes	rmed? 2₽No	death? 1 ☐ Yes	2 No
Χ	s certi	To Be	25. Was case referred to medicat examiner? 1 Yes 2 No	Hospital: 1 Inpa	tient 2	ER/Outpatien	t 3 DO	Othe	AC-		(Check only one 5 ☐ Resid		Other (Sec	200
n of	ng Phy ter thi		27. Manner of Death 1 ☑ Naturat 5 ☐ Pending	28a. Date of In (Month, D		28b. Time of Injury		Bc. tnjury Work			8d. Describe			ny)
sio	Attending ir death. ector: After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not b	1			М	1 🗆 \	/es 2□N					
Division of Vital Records,	at or At after of Direct	Certification:	4 Homicide determined	28e. Place of I	ntury - At ne etc. (Specif	ome, tarm, str	eet, factory	, office		2	City or Tou		Number or Ru	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) Certifying Photographics (Check only one)	nysician: To the besininer: On the basis	st of my kno of examina stated.	owledge, death ation and/or inv	occurred a vestigation,	at the tim	e, date and pinion, deat	d place, a	nd due to the d d at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	To the To the Comp	ğ	29b. Signature and title of certifier	1/11	>				number				signed (Monti	
	1		30 Namer and address of person who	completed cause of	death liter	n 23a) /Tune	CQ.	89:	27		()	4-0	5-07	
	h		Dr. Gary Litt.	le 3001	Hos	spetal	- Du	ie	Che	verl	ly Pri	da	20786	
	Sta Registr	_	31. Date filed (Month / Day, Year) MAY 0 2 200		trar's Signa	ature	D							

07-03051	07-03051	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Charles Robert Anderson 2007 14118

		1- For State Certificate of Death Reg. No.										1				
Physicia Medical Examin	ner		pert A	nderson							Date of Death Month April 21, 20	Day	Year		3. Time of Death 1054 hrs	
^)		4a. Facility Name (if not institution 4070 Lower Wharf Ro	=	number)		4	b. City, To I ndian		ocation of	Death			ounty of	Death		-
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under		If Under	24Hrs.	8. Date of Birt	n(MM/DD	/YYYY)	9. Birti Foreigi	pplace (State or DC	_
Director		219-72-3785	1X M 2 F	48	3	Yrs.	Months	Days	Hours	Min.	May 1	4,19		Cou	Wa/shingtor	n
any	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	catio	on							_	10d. Inside City Limit	its
Maryland 28a-f show	ō		narles		Indi	an	Head								1 Yes 2 X	10
J 5 5.9	Director	10e. Street and Number 4070 Lower Wha	arf Road				10f. Zip C	ode 640			. 10	g. Citizer US		t Coun	try?	
h with th	- 1	11. Marital Status	12. Was De	ecedent Ever in t	J.S. 13.		Decedent	of Hispa			cify Yes or No-		Race -		an Indian, Black,	\neg
											Rican, etc.) White, etc. Specify: White				hite	
hours a natura Examir	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use re										work done 16b. Kind of Business/Industry				
5-0036 led within 72 hours after tygiene. other than "natural", c	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of wo during most of working life. DO NOT use retire 12										Glazier					
다 골炎을 뭐											e (First, Middle, Maiden Surname)					-
2127 ould be: Mental marke c event	Joseph Anderson Charlotte Ande 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Num															
MD nd 2 sho alth and m 27 is		Diane Anderson	n/Wife		353	12	2th S	t. A	Apt.	5 ,C	olonia:	L Bea	ach,	VA	22443	
Baltimore, MD 2121; permit. Pages 1 and 2 should be fil Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event,		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Burial 2 X Cremation 3 Removal from State Brinsfield-Echols Crematory or other place)									Date 20c. Location - City or Town, State 4/27/07 Charlotte Hall, MD					
altimore, mit. Pages I ar partment of He portant: If ite	ŀ	21. Signature of Euneral Service Licensee MOOQ / 22. Name and Address of Feelily C													nail, MD	_
	1	211 St. Mary's 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi									e. La l	Plata	a.MD	2	0646	
Physician /Medical		failure. List only one cause	on each line.										, or hear	1	Approximate Interva Between Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. <u>Farly o</u> Due to (or as	a consequence	of live	odc	ntn 12 one int	coxic	chen e ation	e com	pined wit	h	_		-	\dashv
	اقِ	Sequentially list conditions, if any, leading to immediate		a consequence	of):										<u> </u>	\dashv
	티	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence	of):											_
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8760, tiffcate be executed ng physician and as the burial - trans	n/Medical	X UNPENDED IF FEMALE:	#23a,2	7,28a-f,	perME,g	869	7/26	5/07 '	TT			234 6	Date of d	elivery		_
B B E O		23b. Was decedent pregnant in the past 12 months?	1 Live		2				Ectopic	pregnand	У		onth	_	ay Year	
Box 68' re death certiff the attending led for use as 1	₽L		known 9 death	h nown	5		er (Specif									
ords, P.O. v requires that the s been signed by should be detache		Part II. Other significant condit	ions contributing	to death but not	resulting in the	ne un	derlying c	ause giv	en in Parl	t I.					he cause of death?	
ords, we requires us been sign should be	efed										24a. Was a		24b. W	ere aut	opsy findings availab	ole
of Vital Records, ng Physician: The law requirement ther this certificate has been st meral director, page 2 should I	Completed										autops perform	ned?	de	ior to co ath? Yes	ompletion of cause of	
Vital Recysician: The I	ğ B	25. Was case referred to medical examiner?					26		f Death (0	Check on				<u> </u>	2 10	
n of Viding Physic	우.	1 Yes 2 No 27. Manner of Death	Hospital: 1	Inpatient 2	ER/Outpati				ther ₄		Home 5 F	Residence			Scene	_
_ ≛ . <.21	Certification:	1 Natural 5 Pend 2 Accident Inves	(Mont	h, Day,Year) 4/21/07	FNd 10	•			s 2 X		unk	,,,,,				
Division tal or Attendit rs after death. al Director: A led in by the fu	Ĕ	3 Suicide 6 X Could		ce of Injury - At h				ffice bui	lding, etc.		or Town, St	ate)			al Route Number, Cit	· 1
To the Hospital within 24 hours. To the Funeral completely filled											_		MD			
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the		one) 2 Medical Exam	miner:On the basis and manner:	of examination a			on, in my o	pinlon, d	death occu							
	Σ	29b. Signature and title of certifie		0 8				icense r D.C.M.				29d. Dat April 2			th, Day, Year)	
		30. Name and ad ress of person	who completed cau	ise of death (Iter	n 23a)		`		_			ک ۱۱۱میر د	,0			= 1
DB 1	4	Margarita Korell MD.	Assistant Me	dical Exami	ner 111		nn Stree	et, Bal	timore,	MD 21	201					T)
Sta		31. Date filed (Month, Day, Year) S 2007 32. Registrar's Signature														- 1

DHMH 17 Rev 1/2001

Registrar

APR 17 2007

07-02783	
Moses K.	Anderson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate of Deat Registrar	h	Reg. No. 2007 4 2
Physician/	Decedent's Name (First, Middle,Last)	2. Date of D Month	Day Year 4000 has
Medical Examiner		April 12 Town, or Location of Death	4c. County of Death
	Prince George's Hospital Center Chev		Prince George's
Funeral Director		er 1 Year If Under 24Hrs. 8 Date of Jan 1	Fighth(MM/DD/YYYY) 9. Birthplace (State or Foreign DC Country)
, u	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
nd show s	Md Prince George Seat Pleasan	t	1 XYes 2 No
72 hours after death with the Maryland n "natural", or items 23s or 28s-f show any al Examiner must be notified at ouce. eted by Funeral Director	10e. Street and Number 7018 Greig Court #202		10g. Citizen of What Country?
r death with or items 23 must be no	1 Never Married 2 X Married Armed Forces? If Yes, special Yes 2 X No	ent of Hispanic Origin? (Specify Yes or fy Cuban, Mexican, Puerto Rican, etc.)	White, etc.
is after in all, mingr	or Dates:	No specify: Occupation (Give kind of work done	Specify: BTACK 16b. Kind of Business/Industry
5-0036 ed within 72 hour lygiene. to ther than "natu he Medical Exant Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of wo	rking life. DO NOT use retired)	None
5-003(lied within Hygiene. I other that the Wedie	12th 17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Midd	
7 = A = T	Moses J. Anderson	Sarah Mart	
houl houl	Marlene Anderson (Wife) 7018 Gre	eig Court#202 S	Number, City or Town, State, Zip Code) 20713 eat Pleasant Md.
ore, ML es 1 and 2 s of Health a If item 27	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Na crematory or other place)	1)	20c. Location - City or Town, State
드 ~ 일 문 눈 [4 Donation 5 Other Specify: Lincoln Mem 21. Signature of Funera Service Linese: 22. Name and	Cem <u>04/19/07</u> Address of Facility	Suitland Maryland Wash, DC 20011
Balti permit. Departin Imports injury o	Surand Muenes Tyrone	J. Young 719	Kennedy Street NW
Physician Medical	23a. Part / Enter the disease, or comprisations that caused the leath. Do not enter the mode failure List only one cause on each in a	of dying, such as cardiac or respiratory	Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death) a St wound to neck and chest Due to (or as a consequence of):		Death
	Sequentially list conditions, b.		
red nsit Examiner	if any, leading to immediate cause. Enter Uncertying Course (Disease or injury that initiated		
ecuted and and transit			
2. ₃	UNPENDED AMENDED		
3760, ificate be exign physician s the burial	123h Mac decedent preapant in the	3 Ectopic pregnancy	23d. Date of delivery Month Day Year
Box 687 death certifi. he attending d for use as t	Dast 12 months?		-
that the death cent by the true of the true of the attend detached for use by Physicia	Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I. 23e. I	Did tobacco use contribute to the cause of death?
ires that the signed by be detacled by F		1	Yes 2 No 3 Probably 4 Unknown
Records, The law requires freate has been sign, gage 2 should be		a	Was an 24b. Were autopsy findings available prior to completion of cause of death?
ician: The la scortificate h		1 V Y	Yes 2 N 1 ✓ Yes 2 No
Vital ysician: his certil director	25. Was case referred to medical examiner?	26.Place of Death (Check only one) DOA Other Nursing Home 5	Residence 6 Other:
Division of Vital Records, tal or attending Physician: The law requirers after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be refification: To Be Completed	27 Manner of Death 289 Date of Injury 28h Time of Injury		ribe how injury occurred stabbed
Division o spital or Attending sours after death. neral Director: Aft filled in by the fune Certification:	2 Accident Investigation 3 Sulcide 6 Could not be determined		ion (Street and Number or Rural Route Number, City wn, State) unk Street, Washington , DC
Division of Vital Records, P.O. Box 687 To the Ilospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician		ne time, date and place, and due to the my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	and manner stated. 29b. Signature and title of certifier 2	9c. License number	29d. Date signed (Month, Day, Year)
	(lines 2	O.C.M.E.	April 13, 2007
IR T	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street,	Baltimore, MD 21201	
State	20 Decistoria Signatura		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie (1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 10:45 PM Davis Sangai Abe /Medical April 17 2007 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 12951-A Clarksville Pk. Highland Howard If Under 24 Hrs. 8. Date of Birth Hours Min. Nov. 30, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days ^Y27923 Months 537 14 5056 1**₹** M 2 ☐ F 83 Oregon Yrs. Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show or other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Howard Director Highland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 12951-A Clarksville Pk. 20777 by Funerai USA 12. Was Decedent Ever in U.S. Amed Forces?

12 Yes 2 No 1964- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: Asian American 3 Widowed 4 Divorced Year or Dates: 1975 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Industrial Photographer Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Chozo Abe Toshiko Minami 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12951-A Clarksville Pk. Highland, MD K. Esther Abe/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Crownsville Vet. Cem. 4/20/2007 Crownsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licenses M01442 4112 Old Columbia Pk. Ellicott City, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 57 **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit certificate be executed Due to (or as a consequence of): attending physicien Division of Vital Records, P.O. Box 68760 Physician/Medical as the l IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 PH 1 Yes 2 No or Attending Physiclen: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 2 000 Other. 4 Nursing Home 5 Besidence 6 Other (Specify) 2 1 Yes 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be 3 T Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title Joss roads, Baltima State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day2007 Year ADYT1 25, 10:25 PM Physician Keith Earle Brown /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Dealh 4b. City. Town, or Location of Death Examiner Frederick Frederick Homewood at Crumland Farms 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June | 17, 1946 9. Birthplace (State or Foreign 5. Social Security Number 045-42-3813 **Funeral** Mary Land 1 XM 2 ☐ F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County r than "naturel", or items 23a or 28a-f ehow the Medical Examinar must be notified at Frederick Maryland Frederick 1 Tes 2 No Director 10g. Cilizen of What Country? 10e. Street and Number 10f. Zip Code 21702 7341 Hayward Road death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ A If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Golf Course Greens Keeper 12 permit. Pages 1 and 2 should be filed v
Department of Heelih and Mental Hygies
Important: If item 27 is marked other tt
eny injury or other treumatic event, III.s 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Alida Haller Herbert E. Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7341 Hayward Road, Frederick, MD 21702 Mrs. Alida H. Brown, mother 20b. Place of Disposition (Name of crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Mount Olivet Cenetery April 30, 2007 Frederick, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Fervice Licens 22 Keeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) month **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical 23c. If yes, oulcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 1 Yes 2 Yes 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred To the Hospitel or Attending F within 24 hours after death. To the Funarel Director: After 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 16428 leted cause of death (Item 23a) (Type, Print) on who com 15 M.D., 300 West Ninth Street, Frederick, MD 21701 Casper E. Cline III 31. Date filed (Month 32. Registrar's Signature State Registrar

O

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death APRIL 25, **Physician** 2007^{ear} HAROLD GREY BOND 9:26A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav) 5. Social Security Number **Funeral** Months Days Hours Min. 1 X M 2 □ F 74 Director Dec. 5, 1932 Alabama 424-38-1224 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a State 10b. County 1XYes 2 No Directo Maryland Frederick New Market 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with then tof Health and Mental Hygiene. ns 23a or 7 21774 5743 Windsong Court U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 M Yes 2 N 1 949-52
If Yes, Give
Year or Dates: 1957-61 ral", or items ? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White "naturai", the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) linguist/analyst 12 Federal government other 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Franklin Bond, Sr. Sue Phillips 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 is other tra Laurel K. Bond/wife New Market, MD 21774 5743 Windsong Ct. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If its any injury or o once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/26/2007 4 Donation 5 Dother (Specify) All County Cremation Sykesville, MD 21. Smature of Funeral Service Licer 22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ventricellar tacky arrhythmia 40 Nex /Medical Due to (or as a consequence of) **Examiner** oranary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Division or Vital Records, P.O. Box 68760, 完 the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): physician at the burial Physician/Medical attending pl for use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Winknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an nas autopsy performed? Yes 2 No certificate ha Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA ို After this of funeral direction Date of Injury (Month, Day Year) Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No thours after death.

-uneral Director: A
ely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar

0

31. Date filed (Month, Day, Yeal)

MAY 0

2 2007

DHMH 17 Rev 1/2001

Frederick Memorial Hospital, Frederick MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, Leigh Williams MD

. Registrar's Signature

			1 - For State Registrar/AMFND#50enFH4/2	State of Maryl		artment			nd Mental I	Hygien	2001	14124
	Wagaling	k gr	Decedent's Name (First, Middle, Last,						2. Date o	Death		3. Time of Death
4	Physici		CHARLES VALENTI	NE BOLINGER	JR.				Month April	8.	2007	12:30 P M
	/Medic		4a. Facility Name (If not institution, give			4b. City, 1	Town, or	Location of			c. County of Deat	
1			12805 Marlow Pl.			Si1	ver	Sprin			Montgome	ry
	Funeral	1	5.155 9 Se 20 0 N 57 G 4 5 6. Set	x 7. Age (In)	rs. last birthday)	If Under Months	1 Year Days	If Under 2	Min. (Month	, Day, Yea	r) Co	hplace (State or Foreign untry)
*	Director		230 30 3343	JM 20 F	68 Yrs.				Sep.	25, 1	938 Jean	nette, PA
	and **		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Le	ocation						10d. Inside City Limits
	/anyl	ō	MD									1X Yes 2 □ No
	28a-	ect	MD Montgome 1 10e. Street and Number	ТУ	Silver	10f. Zip				10g. (Citizen of What Co	untry?
	with se or	<u></u>	12805 Marlow Place				2090	1/4			U.S.A	,
	ns 23	Funeral Director	11. Marital Status	12. Was Decedent Ever i	n U.S. 13.				in? (Specify Yes o Puerto Rican, etc.	r No-	14. Race - Ame	rican Indian,
(0	riter	F.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No					Puerto Rican, etc.)	Black, White	
Ö	rai', c	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2	2XI No	Specify:			Specify: B1	аск
21215-0036	72 hours after death with the Maryland 'natural', or items 23s or 28s-1 show dissi Exercit at must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usua	l Occupa	ition uring most	of working	16b.	Kind of Business/	Industry
2	ithin	du	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of wor DO NOT us	e retired,)				
2	led w lygier her th		9		Pain	ter		40 14 15			corating	
ind	be fill	Be	17. Father's Name (First, Middle, Last)						's Name (First, Mid		en Sumame)	
7/8	outd I Mer narke	2	Charles V. Boling		101 14 27		(0)		la L. St			
Maryland	12 st h and 7 is n traun		19a. Informant's Name/Relationship (Ty						or Rural Route Nu			
	1 and Healt em 2 ther		Patricia Bolinger 20a. Method of Disposition						.1ver Spr	-	Location - City or	
Baltimore,	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. Int: if item 27 is marked other than "natural; or items 23a or 28a-1 show yry or other traumatic event, if a Modical Exercities in maske relified at		1 ☑ Burial 2 ☐ Cremation 3 ☐ F	removaniiom State	b. Place of Dispo cemetery, cre			- 1				
臣	그른판중		4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licens	A - 1	Gate of			A Facility	McGuire	Fune	Silver S	Spring, MD
$\mathbf{B}^{\mathbf{a}}$	Dermi Depa impo any ir		Dhomas 1	Claston	12.25							D.C. 20012
9			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the c				-			iriig coii,	Approximate
	Physician		Immediate Cause (Final	•								Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a con		llular	Ca	rcinon	na			
ja j	Examiner				, ,							
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Duvito (or as a son	buquanes of):							
	nd nd transi	Examiner	Cause (Disease or injury that initiated events	3 .								
Ö,	e exe	Ä	resulting in death) Last	Due to (or as a con	sequence of):							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dical		d.								
×	eath certific attending p	Physician/Med	fF FEMALE:	3c. If yes, outcome of pre	anancu							
Box	atten atten for us	lan	in the past 12 months?	1 Live birth 2 ☐F	etal death 3	□Ectopic pre					23d. Date of deli Month	Day Year
P.0.	at the de by the a tached i	yslc	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	ordeam 5L	_ Other (spe	9Cily)					
	res that I igned by be deta		Part If. Other significant conditions con	ntributing to death but not	resulting in the u	inderlying ca	ause give	n in Part I.	23e. [oid tobacco	use contribute to	the cause of death?
Records,	uires sign	d by	Stage five Rena	l Failure or	Hemodi	alysis	5		1	☐ Yes	2 □ No 3 □ Pro	obabíy 4 XUnknown
Ö	w requir been si should	Completed							24a. V	Va.s.an	24b. Were au	topsy findings available
Re	he lav e has age 2	E							P	utopsy erformed?	prior to death?	completion of cause of
	ifficat		25. Was case referred to medical					26 Place (of Death (Check or	es 2 🛣 N	to 1 ☐ Yes	2 No
5	Physician: r this certifica ral director, i	o Be	avaminar?	lospital:	2 🗆 ER/Outpatie	nt 3 DO	A Othe		sing Home 512 F		6 □Other (Spec	cufu)
o	or thi	T ;	27. Manner of Death	28a. Date of Injury (Month, Day Yea			Bc. Injury Work				jury occurred	,,,,,
Ö	Attending r death. ector: After by the fune	atio	1 XNatural 5 Pending 2 Accident investigation	(Month, Day 1 da	r) Injury	М		r ∕es 2 □ N	lo			
Division of Vital	er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, st	reet, factory,	, office			on (Street : Town, Sta		ral Route Number,
Ö	tal or rs afte al Dir ed in	Cer		January, etc. (ep					,		,	
	To the Hospital or Atlanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical Exami	sician: To the best of my ner: On the basis of exam	knowledge, deat	th occurred a	at the tim	e, date and inion, death	place, and due to	the cause	(s) and manner as	stated. to the cause(s)
	the hin 2 the f	Med	one)	and manner stated.			License					-
			29b. Sign can and title of certifier	Ham 10	MIN	1					ate signed (Monti	
7	O	- V	Nouvel 11	Juais	ハリ		D005	5522	77.35	Ap	ril 11,	2007
			Robert H. Gerard				zer (Spring	MD 209	10		
	Sta	te_	31. Date filed (Month Day, Year)	32. Digistrar's S	ignature				, 200			
	Registr		31. Date filed (Month Day, Year) APR 18 20	107 Segue		ands:	7					

			For			d / Depa	artment of H	lealth a		•	iene	11.125
			1 - State Registrar			Cei	tificate of	Death			g. No.	14123
	Physici	an	1. Decedent's Name (First, Middle Gladys Louise						1	Date of Deat Month	Day Year	
	/Medic		4a. Facility Name (If not institution.				4b. City, Town, o	r Logation of		ril 15	5, 2007 4c. County of Dea	1136 A ^M
	Examin	er		,				LOCATION OF	Death			
	Funeral		Laurel Regiona 5. Social Security Number	6. Sex 7. Ag	e (In yrs. la	ast birthday)	Laurel If Under 1 Year	If Under 2	4 Hrs. 8.	Date of Birth (Month, Day,	Prince G	rthplace (State or Foreign Country)
	Director		578-48-5844	1 □ M 2 X □ F	84	Yrs.	Months Days	Hours	Min. J	JL 12	1922 Vin	cginia
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City	. Town or Lo	ecation					10d. Inside City Limits
	f sho	ō		Coomoolo								1 ☐ Yes 2 📉 No
	28a	Director	Maryland Prince	e George's	Бел	tsvil	10f. Zip Code			10	Og. Citizen of What C	ountry?
	hours after death with the Maryland tural', or Itams 23a or 28a-f show al Examiner and be nutified at	al Di	11617 35th Ave				2070)5			United S	
	deat	Funeral	11. Maritaf Status	12. Was Decedent Armed Forces?	Ever in U.S	S. 13.	Was Decedent of H f Yes, specify Cuba		in? (Specify	Yes or No-	14. Race - Am	erican Indian,
Š	or its	y Fu	1 Never Married 2 Marri		No		1 □ Yes 2 No	Specify:	1 dello rice	11, 610./	Bfack, Wh	ste, etc.
Ş	hours tural',	ed by	3 X Widowed 4 □ Divorced	Year or Dates:						1 .	B	lack
V	in 72	plete	15. Decedent (Specify only highes	t grade completed)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of	of working		16b. Kind of Busines:	s/Industry
21215-0036	filed within 72 Hygiene. other than "nalent, It we Medic	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	U.S.	Postal W	orker			U.S. Post	Office
ם	al Hyg I othe Vent,	BeC	17. Father's Name (First, Middle, I	_ast)					's Name (Fi	rst, Middle, N	faiden Sumame)	
Maryland	2 should be filed within 72 hours after death with the Marylan and Menhal Hyglerie is marked other Hyglerie is marked other than "naturat", or itams 23a or 28a-1 show aumatic event, the Madical Exemples covert with the Madical Exemples covert.	To	3	Hoban		1		Lucy			ird	
Mar	s 1 and 2 should if Health and Men item 27 is marke other treumetic		19a. Informant's Name/Relationsh								City or Town, State,	Zip Code)
a)	1 and 2 Health 16m 27		Frances M. Hom/I	isq.	20b. Pla	ace of Dispo	D St. NW,		ingtor Date			r Town State
ě	ages ant of it: if it		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		Ce	metery, crer	natory or other place oln Cemet	1		-		
altimore,	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service L		T C	22	. Name and Addres	ss of Facility			Brentwood,	
ñ	Den Imp		> prof 7	mr M	00956	T1	nibadeau 33 Gist A	Mortua venue,	ry Se	rvice, Silver	P.A. Spring,	MD 20910
			23a. Part1. Erker the disease, or shock, or heart failure. List of	complications that caused only one cause on each li	the death							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	DEHYDRA'	TION							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as		ence of):						
		- La	Sequentially fist conditions, if any leading to immediate	b. PNEUMON Due to (or as		ence of):						
	uted d ansit	Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c CONGEST			TATI IID E					
ó	be executed sician and burial-transit		resulting in death) Last	Due to (or as			ALLUXE					
3760,	# % E	lical		d								
X 68	ertifica ling ph e as th	Med	IF FEMALE:									
. Box	leath certific attending p	lan/	23b. Was decedent pregnant	23c. If yes, outcome	2 Fetal	death 3	Ectopic pregnancy				23d. Date of de Month	elivery Day Year
		Physiclan/Med	in the past 12 months? 1 □ Yes 2 ፟ No 9 □ Unknown	4 □ Pregnant at 9 □ Unknown	ume or ge	atn 5L	Other (specify)					
J.	The law requires that the ste has been signed by th page 2 should be detache	by Ph	Part II. Other significant conditio	ns contributing to death b	ut not resu	Iting in the u	nderlying cause give	en in Part I.		23e. Did tob	acco use contribute	to the cause of death?
ras	quires an sig uld b	ed b	SENILE DEMENTI	.A						1 🗌 Ye	s 2 📉 No 3 🗆 F	robably 4 Unknown
Records,	law re as bee 2 sho	Completed	POOR ORAL INTA	KE						24a. Was ar		utopsy findings available
ř		Com								autopsy perform	ged? death?	completion of cause of s 2 \(\subseteq \text{No} \)
/Ita	sician: The certificate rector, pag	Be (25. Was case referred to medicaf examiner?						of Death (Cl	neck only one	•)	
or Vital		²	1 ☐ Yes 2 🔀 No	Hospital:			t 3 DOA Oth	4 🔲 Nurs			nce 6 Other (Spe	ecify)
	De Te	tlon	27. Manner of Death 1 X Natural 5 Pending 2 Accident investig		y Year)	28b. Time of Infury	Worl	/at k? Yes 2.∐No		Describe ho	w injury occurred	
Division	al or Attending s after death. i Diractor: After id in by the fune	fica	3 ☐ Suicide 6 ☐ Could n	ot be	ury - At hor	me, farm, str		703 2 11		Location (Str	reet and Number or F	Tural Route Number.
S	al or safter	Certification;	4 Homicide determi	building, et	c."(Specify,)	eet, factory, office			City or Town		
	ospit houn unera		29a. Certifier 1 K Certifying	g Physician: To the best examiner: On the basis of	of my know	vledge, death	occurred at the time	ne, date and	place, and	due to the ca	use(s) and manner a	s stated.
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	one,	and manner sta	ated.	- and of in			- OCCUITED A			
	2 1 2 2	=	29b. Signature and title of certifier		VI		29c. License				d. Date signed (Mon	
	y		30. Name and address of person v		451CI		D005	4547		Ap	ril 16, 2	007
			William J. Cri					Road.	#350.	Laure	1, MD 207	07
	Sta	te	31. Date filed (Month, Day, Year)	32 Apristr	ar's Signati	ure 4						
	Registr	ar	APR 18	2007	es L	× As						

			1 - For State Registrar	State	of Marylar		artment of I rtificate of		Mental Hy	giene Reg. No.	007	14126
			1. Decedent's Name (First, Middle, L.	ast)					2. Date of De	ath		3. Time of Death
	Physici		Shirley Holmes	Brand	t				Month April	Day	Year	10:38 M
}	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and n	umber)		4b. City, Town,	or Location of Dea			County of Dea	
	LXdiiiii	-	Manor Care- Si	lver Sn	ring		Si1,	ver Sprin	a cr	١,	Mont co	more
-	Funeval			Sex	7. Age (In yrs.	last birthday)		If Under 24 H			Montgo	rthplace (State or Foreign
	Funeral Director			1 □ M X 3 F		Yrs.	Months Days	Hours Mi	n. (Month, Da	y, Year)	0	ountry)
	Director		578-20-6815 Usual Residence of Decedent		84				Feb. 2	3, 1	923	Massachusetts
	land		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation					10d. Inside City Limits
	Aany	õ										1 ☐ Yes 2 ☐No
	the 1	Director	Maryland Monte 10e. Street and Number	gomery		Sil	ver Spri	ng	·····	10a Citia	en of What C	
	Mith or						10f. Zip Code			iog. Citiz	en of what C	ountry?
	be filed within 72 hours after death with the Maryland Ital Hygiene. Ident then "natural", or items 23a or 28a-f show event, the Madical Examiner must be notilled at	Funeral	3126 Gracefiel				20904				USA	
	g = 1	Jue	11. Marital Status	12. Was De Armed F	cedent Ever in U forces?	J.S. 13.	Was Decedent of If Yes, specify Cut	Hispanic Origin? oan, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	1-	 Race - Am Black, Whi 	erican Indian, ite, etc.
9	afte a di	ΥF	1 Never Married 2 Married	1 ☐ Yes	2⊠No iive		1 ☐ Yes 2 ☑ No	Specify:			SpecifWhi	te
ğ	in in it	d by	3 ☑ Widowed 4 ☐ Divorced	Year or	Dates:							
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7	thin	npi	Elementary/Secondary (0-12)		(1-4or 5+)	life.	kind of work done DO NOT use retire	ed)	9			
7	N D D D	ő	12			Inv	entory A	Administ	rator	Trai	nsport	ation
ğ	_ 0 5	Be (17. Father's Name (First, Middle, Las	t)				18. Mother's N	ame (First, Middle,	Maiden S	Surname)	
ā	should be nd Menta marked imatic sy	ToE	Charles E. Rup	key				Olive	P. Knigh	t		
Maryland	es 1 end 2 should b of Health and Ment item 27 is marked r other traumatic s	_	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Stree	t and Number or I	Rural Route Numbe	er, City or	Town, State,	Zip Code)
S	15 a 27 ts 27 ts 1 trait		Ronald Stephen	Holmes/	Son							ng, MD 20901
Ġ	1 end Health em 27 thar tr		20a. Method of Disposition		20b. I	Place of Dispo	sition (Name of		Date	20c 1 oc	ation - City or	r Town State
altimore,	Pages nent of int: if it iry or o		1 ☐ Burial 21☐ Cremation 3	Removal from	State	cemetery, crei	natory`or other pla	ADI		200. 200	ation only of	Town, Glato
<u>=</u>	men tent jury		4 □Donation 5 □Other (Spec		Met		tan Crem					, Virginia
Ö	permit. Pages Depertment of Importent: If it eny injury or o		21. Signature of Funeral Service Lice	ensee		$\mathbf{F}_{\mathbf{r}}^{22}$	Name and Addr	ess of Facility COILINS	Funeral	Home	e Inc.	
m	g Q E # 9	7 IV	Aoms &	العمل	7	500) Universi	ty Blvd., W,	Silver	Sprin	ng, MD	20901
			23a. Part1. Enter the disease, or con shock, or heart failure. List on	nplications that	caused the dea	th. Do not ent	er the mode of dy	ing, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final									Onset and Death
}	/Medical		disease or condition resulting in death)		cation Pne							
	Examiner			Seps		quence or):						
		16	Sequentially list conditions, if any, leading to introduce cause. Enter Underlying	b	o (or as a cons	uenco of						
	sit ad	Examiner	cause. Enter Underlying Cause (Disease or injury	000 ((in as a conse	perica cap						
	and tran	carr	that initiated events resulting in death) Last		tos Molli							
Ö,	ien a	Û	Toolstang an acadiny East		(or as a consec		_	_				
8760,	cale be executed physicien and the burial-transit	dical		d. Chro	nic Obstr	uctive Po	almonary D	isease				
9	tifica ng pt as ti	40	100 E									
. Box	The law requires that the death certificates hes been signed by the ettending I agge 2 should be deteched for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn		TE			2:	3d. Date of de	alivery
m	deatl	Cia	in the past 12 months?	4∐Preg	birth 2 ☐ Feta nant at time of o		Ectopic pregnand Other (specify)	;y 			Month	Day Year
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	that ed b dete	ā	Part II. Other significant conditions	contributing to	death but not res	sulting in the u	nderlying cause gi	ven in Part I.	23e. Did t	obacco us	e contribute t	to the cause of death?
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5	w require been sli should b	Completed	ballericia, osceoporos	15, 010	эсрэтэ			·			,,,,,	XX
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	The ete he page	Ю							perfo	rmed? 2 No	death?	s 2 No
Viital	ician: Th certificete ector, pag	0	25. Was case referred to medical					26 Place of D	eath Check only	1		
		To B	examiner? 1 Yes 2 No	Hospital:	Inpatient 2] ER/Outpatier	nt 3 DOA Ot	hor	Home 5 ☐ Resi	- 77	COthor /Co.	an(f.)
ō	Physical distribution		27. Manner of Death	28a. Date		28b. Time o			28d. Describe			эспу)
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Division of		ŧ	4 Homicide determine	d 200. Flat	ding, etc. (Speci	ify)	eet, factory, office		City or To	wn, State)	Number or H	Rural Route Number,
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	Hospital 24 hours e Funeral l ielely filled	edicai	29a. Certifier 1 XCertifying F	hysician: To the	e best of my kn	owledge, deatl	h occurred at the t	ime, date and pla	ce, and due to the curred at the time,	cause(s) a	and manner a	is stated.
	To the Hospital within 24 hours of To the Funeral completely filled	ed	one)	and ma	nner stated.		sugarion, in my			Jaio and	piace, and du	o to the cause(s)
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1	0,		> Kuti	VO	ma.	111	D20	274		Apri]	l 15, 2	2007
			30. Name and address of person who	completed car	use of death (Ite	m 23a) (Tvne	Print)					
			Kirti Vohra, M.		20 m		d., Beth	esda. MI	20817			
eş.	Sta	to	31. Date filed (Month_Day, Year)		Registrar's Sign		a., Decil	Cour H	- 40011			
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State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** Jeannie E. Troll Becraft April 16, 2007 10:15 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring
If Under 1 Year If Under 24 Hrs Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 ☐ M 2 🖵 F Director 014-16-1219 Massachusetts Sept. 29, 1925 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits nd other then "natural", or iteme 23a or 28a-f show event, the Mydical Exporter must be notified at 1 ☐ Yes 2 ₩ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 15123 Vantage Hill Road 20906 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2√☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ★ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Administrative Assistant</u> Personnel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Leonard Faunce Hattie T. Winslow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) F. Robert Troll, Jr./Son 20b. Place of Disposition (Name of Cametery, crematory or other place)

20b. Place of Disposition (Name of Cametery, crematory or other place)

April 20 20a. Method of Disposition April 20 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. Gate of Heaven Cemetery 2007 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. Come 500 University Blvd, W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Cardiopulmonary Arrest /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Renal Failure Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physicien and s the burial-transit Septic Shock Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical d. Vancomycin-Resistant Bacteremia as 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Metastatic Ovarian Cancer 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 🔀 No 1 Yes To the Hospitel or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) · D64100 MID April 17, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smitha Bhikkaji, M.D 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2007 18 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 248 AM Ghareh Babaei 2007 Leila /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hagerstown Washington County Hospital 9. Birthplace Country) If Under 24 Hrs. If Under 1 Year (State or Foreign 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** Months Days 1 □ M 2 🗙 F 50 12/09/1956 Iran 607-39-1317 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 SaYes 2 □ No Director Hagerstown MD Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 Iran 18331 Roycroft Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 🔀 No Maryland 21215-0036 "natural", or ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker Pages 1 and 2 should be filed wient of Health and Mental Hygier It: If Item 27 Is marked other thy or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fatemeh Ghafari Babaei 2 Ghareh Reza 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18331 Roycroft Dr., Hagerstwon, MD Behnoosh Binesh-daughter Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any injury or otl 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State National Mem. Park 04/21/2007 Falls Church, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7482 Lee Hwv.22042 National Funeral Home, Falls Church, VA mari 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Primary CNS **Physician** /Medical EmBolism Examiner -si dec Equantially list our differs, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner executed 6 and burial-tran Due to (or as a consequence of): P.O. Box 68760 attending physician pe Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month for in the past 12 months 5 Other (specify) 1 Yes 2 No the detached 9 ☐ Unknown Š Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð venas 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an Selzine Disade autopsy performed? certificate has 2 No 1∐ Yes 25. Was case referred to ical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3□ DOA 1 Yes 217740 1_Inpatient this 28c. Injury at Work? 27. Manne Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of funerai Certification: After 1 Injury Hospital or Attending 5 Pendina 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 ☐ Homicide 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 2 29d. Date signed (Month, Day, Year) 29c. License number Hospiralis 29b. Signature and title of certifier ۵ ပ

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. gistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 12:40 P M David Arthur BARKLEY April 18 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NMS Health Care of Hagerstown Washington Hagerstown If Under TYear If Under Birthplace (State or Foreign Country) er 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral Months Davs 1X M 2□ F Hours Yrs Director 67 9 1939 Pennsylvania 185-32-8517 Aug. Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1XYes 2 No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death Funeral 209 Devonshire Road 21740 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed by Specify: 3 Widowed 4 Divorced White "natural" 16a. Decedent's Usual Occupation other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be f Health and Mental Item 27 is marked o ပ Arthur Clair Barkley Florince Marguaret Knust 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 Devonshire Road, Hagerstown, Md. Elizabeth B. Barkley - Wife 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Memorial Park 4/21/07 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Coronary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Physician/Medical Examiner Disease eripheral The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buris use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month 5 Other (specify) cate has been signed by the page 2 should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ponknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1☐ Yes 2 No or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 27. Manne of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Natural Injury 5 | Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fi 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0060396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5N-5+1 worltou 31. Date filed (Month 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** JOHN FILMORE BURNS 15, 200, 4c. County of Death 7:35 а April /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Annapolis

"Linder I Year | If Under 24 Hrs. Anne Arundel Medical Center <u>Anne Arundel</u> 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days Min 1X M 2□ F Yrs 63 10-26-1943 Washington, DC Director 216-40-6565 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No ms 23a or 28a-f sl must be notified Director Maryland Queen Anne Stevensville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 312 Queen Anne Road 21666 U.S.A. Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: ģ 3 ☐ Widowed 4 X Divorced White Completed Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Automotive 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Peter Burns Madeleine Norris ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Michael Burns - Son 13905 Old Stage Road, Bowie, Maryland 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Fort Lincoln Cemetery 104/21/2007 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. WChelle M01491 Hyattsville, MD 20781 Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy 2**X** No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Pfint) (-In) 32. Registrar's Signatu 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician a_M William Ralph Barnhardt April 12, 2007 8:52 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1X M 2 T F Director 577-50-1253 06/17/1938 68 Washington, D.C. Usual Residence of Decedent 10c. City. Town or Location a or 28a-f show t be notified at 10a, State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Director MD Prince Georges Landover 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20785 "natural", or items 23a 1212 Hill Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 \(\text{No} \) No 1955— If Yes, Give 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Specify þ 3 Widowed 4 Divorced Year or Dates: 1959 Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Private Educational permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item Z7 is marked othe any injury or other trainments. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Andrew Barnhardt Frankie Carrie House 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1212 Hill Road, 20785 Rachel D. Barnhardt/wife Landover, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery | 04/18/2007 | Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 21. Signature of Funeral Service Licensee 23a. Part1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Brentwood, MD 20722 Immediate Cause (Final **Physician** disease or condition resulting in death) Sepha /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Ulnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2**X** No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury 28h. Time of 28d. Describe how injury occurred Certification;

certificate be executed Box 68760, attending physician the as use ō ed by the a detached f Division or Vital Records, P.O. signed I

this

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

Medical

items 23a

than "

hours after

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Baltimore, Maryland 21215-0036

sician and burial-transi page 2 L,

• Hospital or Att,

• Hours after death,

• heral Director: Att.

• ed in by the fur-

28c. Injury at Work? (Month, Day Year) 1 Natural 5 ☐ Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier

and title of certifier

License number

29d. Date signed (Month, Day, Year)

ess of person who completed cause of death Item 23a) (Type, Print) ex

State Registrar 31. Date filed (Month, Day, Year) APR 1 7 2007

4 □ Homicide

32. Registrar's Signature

Division or Vital Records, To the Hospital or Attending Physician: After within 24 hours after death

To the Funeral Director:

Certification:

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

31. Date filed (Month.

Medical

29b. Signature and title of certifier M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

6 ☐ Could not be determined

APR 2

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d, Date signed (Month, Day, Year)

2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D0061652

11350 PEMBROOK Sq. SUITE 304 WALDORF, MD 20603 ATUL KATYAL, MD

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

32. Pogistrar's Signature

and manner stated.



07-02886 Hazel Byrnes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

nazei bymes		State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Registrar	13
Physicia Medical Exami	ın/	1. Decedent's Name (First, Middle,Last) Hazel W. Byrnes 2. Date of Death Month Day April 14, 2007 3. Time of Death April 14, 2007 1430 hrs	
()	iiei	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
		333 Russell Avenue -Room 452 Gaithersburg Montgomery	
Funeral Director		5. Social Security Number 6. Sex 17. Age (In yrs. last birthday) 86 Yrs. Francisco Fra	nd
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lir	mits
and F show	ь	Maryland Montgomery Gaithersburg 1X Yes 2	No
h the Mary 3a or 28a- otified at o	Director	10e. Street and Number 301 Russell Avenue 10f. Zip Code 20877 U.S.A.	
r death wit or items 2 must be n	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Never Married 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Was Decedent Ever in U.S. Armed Forces? 16. Yes 2 X No specify: 17. Yes 2 X No specify: 18. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify: 19. Was Decedent Ever in U.S. Armed Forces? 10. Yes 2 X No specify: 11. Yes 2 X No specify: 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify: 14. Race - American Indian, Black, White, etc.	
urs afte	ğ	3 X Widowed 4 Divorced of Yes, Give Year 1 Yes 2 X No specify: Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry)	
036 ithin 72 ho ne. r than "na lediral Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 2 yrs Chief Deputy Clerk Montgomery County Circuit Court	
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23n or 28n-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Be Col	17. Father's Name (First, Middle, Last) Charles L. Ward 18. Mother's Name (First, Middle, Maiden Surname) Daisey E. Pope	
MD 2' and 2 should alth and Md m 27 is ms	To	19a. Informant's Name/Relationship (Type, Print) Daniel L. Ward - Nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10503 Brenda Avenue, Ijamsville, Maryland 21754	
imore, Pages I an nent of Her ant: If ite		20a. Method of Disposition 1	and
Balt permit. Departs Import		21. Signature of Funeral Service Licensee 22. Name and Address of Facility iams P.A., Funeral Home 26/01 Ridge Road Damascus Maryland 20872	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate International Control of the cause of the death of the cause	
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death) a. Bilateral Pulmonary Thromboemboli Due to (or as a consequence of):	and
,		Sequentially list conditions, b. Deep Venous Thrombosis	
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): Left Hip Fracture	
uted Id ansit		events resulting in death) Last Due to (or as a consequence of): d.	
be exectician ar	Medical	UNPENDED AMENDED	
68760, certificate be executed nding physician and se as the burial - trans	n/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year	
Vital Records, P.O. Box 68760, system: The law requires that the death certificate be executed his certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial - transit	Physician/	past 12 months? 1 Yes 2 No 9 Unknown The late of death of the state of death of the state of death of the state of death of death of the state of death	
, P.O. res that the signed by be detach	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
cords law requi has been 2 should	Completed	24a. Was an autopsy prior to completion of cause death?	
Rec i: The ifficate		1 ✓ Yes 2 No 1 ✓ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)	
f Vital Physician: er this certif ral director,	e Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other: Scene	
Division of Vital Records, P.O ral or Attending Physician: The law requires that Irs after death al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detac	tion: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury Jan 28, 2007 28b. Time of Injury 1500 hrs 28c. Injury at Work? 1 Yes 2 No Subject fell	
Divisi ital or Att urs after de ral Direct	Certification	2 Accident Investigation 3 Suicide 6 Could not be determined Homicide Homicide 4 Homicide Investigation 5 Suicide 6 Could not be determined Could not be determined Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, or Town, State) 333 Russell Avenue, Gaithersburg, MD	City
Division of Yor to the Hospital or Attending Physhin 24 hours after death To the Funeral Director: After to completely filled in by the funeral	Medical C	2ga. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
F > F 8	₩.	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
		Con Col Haller O.C.M.E. April 16, 2007	
3		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
	ate	31. Date filed (MRDD Rey, Year) 2007 32 Registrar's Signature	
Regist	CI.		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMENI THE ACCUMENT OF THE COLUMN State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg/No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician Apri 9 づるし /Medical 4a Facility Name (If not institution give street and number City, Town, or Location of Death 4c. County of Death Examiner Dring d If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 ☐ M 2 🛣 F 88 Yrs. Aug. 23, 1918 Director 578-22-7789 NC Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Merylend Depertment of Health end Mental Hygiene. Important: if Item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Md. PG Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7315 Calder Drive 20743 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Black þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Domestic Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert Costen Henrietta Lassiter 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7315 Calder Drive
Capitol Heights, Md 20743

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lionel Buggie/son 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Riverdale Crematory 5/3/07 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, MD 22. Name and Address of Facility Hodges & Edwards F.H. Signature of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md. 20746 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Failure to thrive Examiner Due to (or as a consequence of): Physician/Medical Examiner Hyperthyroidism I Records, P.O. Box 68760, S. The lew requires that the death certificete be executed attending physician end for use es the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be deteched Multiple Decubiti 1 ☐ Yes 2 KNo 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed General Debility cete hes 1 ☐ Yes 2 No 1 🗆 Yes 2 No certificate r: After this certifice ie funeral director, p or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ပ္ 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No deeth. neral Director: A filled in by the f 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours of To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only edicai one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 25, 2007 Daima D0058965 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 Saima Khawaja, 11119 Rockville Pike #100, Rockville, Md. 20852 2. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 2 2007 Registrar

ORIGINAL

DHMH 16 Rev 6/95

			For State Registrar	State of Ma		d / Depa		t of H	ealth a		-		007	14135								
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, La John 4a. Facility Name (If not institution, gir Univ. of Maryl	C.	cal	Syste	4b. City,		OP Location o	of Death	2. Date of De Month March	28,	Year 2007 unty of Death	3. Time of Death 17:48 pm								
	Funeral Director		5. Social Security Number 6.			last birthday) Yrs.		1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year) 1951	Co	nplace (State or Foreign untry) TLAND								
9600	ne Maryland 8a-f show alified at	Director	10a. State 10b. County MD CARO	LINE	INE GOLDSBORO							10d. Inside City Limits 1 ☐ Yes 2X No										
	within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28a-f show the Medical Exameter runal to rediffed at	by Funeral	10e. Street and Number 25635 PARADIS 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's 8	12. Was Decedent Ever in U.S Armed Forces? ad 1 _Yes 2 ANo If Yes, Give Year or Dates:		If Yes, specify Cuban, Mexican, Puerto Rican, etc 1 Yes 2 No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CHIEF LINEMAN					Specify:			merican Indian, hite, etc. WHITE								
Maryland 21215-0036	ed within 72 ygiene. nar than "na it, the Medic	Completed	(Specify only highest green (0-12)	ade <i>completed)</i> College (1-4or 5							16b. Kind of Business/Industry UTILITY COMPANY											
ıryland	should be fill of Mental H markad ott matic even	To Be	 Father's Name (First, Middle, Las JOHN CHARLES BI Informant's Name/Relationship 	SHOP		19b. Mailir	na Address	(Street a		IRM	(First, Middle IA HALL Al Route Numb			(ip Code)								
Baltimore, Mai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Itam Medical Exam and injury or other traumatic event, Itam Medical Exam and injury or other traumatic event.		SARAH MELISSA BI 20a. Method of Disposition 1 X Burial 2 Cremation 3 (4 Donation 5 Other (Spec.) 21. Signature of Funeral Service Lice	SHOP/WIFE Removal from State (fy)	c	25635 Place of Disponentery, crer LEY CH	Sition (Name and LLOWS)	ADIS ne of ther place CEME d Addres , HEL	E LAN P) TERY s of Facilit FENBE	4-3 YIN 8	COLDSBOI Date 3-2007	RO, MD 20c. Locate ROCK 1 FUNE	21636 ion - City or T HALL, RAL HO	Town, State MD OME, P.A.								
3760,	by Medical Examiner The burial-transit	lical Examiner	23a Part1. Enter the Isease, or corshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Taraumatic Due to (or as: Motor Cyc Due to (or as: Due to (or as: Due to (or as:	Br consequence cle	eain I uence of): Accid uence of):	njur			oke	Transfer R	1/1	AL EXAMINE	Approximate Interval Between Onset and Death 1 day								
P.O. Box 68	The law requires that the death certifica ate has been signed by the attending phr bage 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic properties of time of death 5 □ Other (standard)									23d. Date of delivery Month Day Year										
	w requires that the stratt is been signed by should be detact	ted by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying caus Cervical spine injury, left tibial-f							•		obacco use contribute to the cause of death? 'es 2 \int \bigve{A}_0 3 \int \text{Probably} 4 \int \text{Unknown}										
of Vital Records,		Completed									perfo 1 ☐ Yes	autopsy performed? prior to completion of cause of death? Yes 2 No 1 Yes 2 No										
Division of Vit	It the Hospital or Attanding Physician: within 24 hours after death. To tha Funaral Diractor: After this certifica completely filled in by the funeral director.	To B	To B	To B	To B	To B	To B	To B	유	To B	25. Was case referred to medical examiner? 1 Ves 2 No 27. Manner of Death 1 Natural 5 Pending 2 Kcident investigation	28a. Date of Injur (Month, Day on 3/27/(Year)	ER/Outpatien 28b. Time of Injury 2:02		8c. Injury Work	or: 4 □ Nu	ırsing Ho	me 5 Resi 28d. Describe	dence 6 [curred	accident
Divi	the Hospital or Att nin 24 hours after d tha Funaral Diract npleiely filled in by t	al Certification:									Felto	Location (Street and Number or Rural Route Number, City or Town, State) Rt 13 & Rt 12 elton, DE 19943										
1	within 24 hu To the Fun completely	Medical	(Check only 2 Medical Example) 29b. Signature and title of certifier	miner: On the basis of and manner sta	examina ted.	tion and/or in	vestigation,	in my op License	number	th occurr	ed at the time,	date and pla 29d. Date si	gned (Month	to the cause(s)								
(8,0		30. Name and Idrae person who Dr. Ronald Tes	completed cause of de					385 eet,	Bal	ltimor		2120									
	Sta Registr	-	31. Date filed (Month, Day, Year) APR 0 6	32. Registra			- · · · · · · · · · · · · · · · · · · ·	,														

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APRIL 11FW-19b per NF. #26 per PHYS. C867.5/25/07 WS.

State of Maryland / Department of Health and Mental Hygiene 1- For Amend #4a, perMD, G867, 5/30/07 TT Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Vera Childs 4:30 p 16, 2007 April /Medical M. Examiner 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Silver Spring

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Bedford Court Montgomery

9. Birthplace (State or Foreign Country) Living 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 3 F Yrs. Director 130-16-0252 93 March 6, 1914 | South Carolina Usual Residence of Decedent with the Maryland 10a State show 10b. County 10c. City. Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 3701 International Drive 20906 death v Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 2 1 ☐ Yes 2 ☑ No Specify. SpecifyBlack 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental Furman Boyce McAdams 2 Minnie V. Sherard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) item 27 ls Ruby M. Shakesnider/ Sister 1721 Randolph Street, NW, Washington, DC 20018 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 21, Westview Cemetery 2007 Anderson, South Carolina 21. Signatury of Faneral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Mitral Regurgitation cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: be executed Coronary Atherosclerosis and burial-tran Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760. attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1☐Yes 2☑No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes ¾ No 3 Probably 4 Unknown Completed Hypothyroid, Macular Degeneration, Osteoarthritis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1☐ Yes 28 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence State (Specify) Assisted 1 ☐ Yes 2XXXNo Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **Living** Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 7 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) D51473 April 17, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathy S. Brenneman 31. Date filed (Month, Day, Year) 1160 Varnum Street, NE, #21, Washington, DC 20017
Registrar's Signature M.D State

Registrar

18

2007

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🦾 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 Physician April 15, Рм 4:00 James Clement Cawood, Jr /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel 4994 Sudley Road West River Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Days **X**M 2□ F June 4, 1936 Washington D.C. Director 70 579-52-8053 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2√XNo Maryland West River Anne Arundel Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or edical Examiner must be United States 20778 4994 Sudley Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

MUYes 2 □ No 19 □

Yes, Give
Year or Dates: 196 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married XX Married 1953 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Yo Specify: Specify: White ģ 3 Widowed 4 Divorced 1964 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Judge Judicial System 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Osbourne ည James Clement Cawo<u>od</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh. Department of Health and Important: If item 27 is m any injury or other traum Katherine K. Cawood / Wife 4994 Sudley Road West River, Maryland 20778 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XXCremation 3 ☐ Removal from State 4/19/2007 Baltimore Crematory Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ocent 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myocardial Infarction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension autopsy performed? has page 2 death? 1 ☐ Yes 2 ☐ No certificate 1∐ Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home XX Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes XXX No 1 🗌 Inpatient Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After (Month, Day Year) Injury 5 Pending investigation 1XXNatural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760 filled in by the funeral Hospital or Attending death. within 24 hours after death To the Funeral Director: completely

State

29a. Certifier

29b. Signature and title

Dr. Jack Lichtenstein 31. Date filed (Month, Day, Year)

APR 17 2007

of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

215 Ridgely Avenue 32. Redistrar's Signature

💥 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D08194

Annapolis, Maryland 21401

29d. Date signed (Month, Day, Year)

April 16, 2007

Registrar

				d / Department of Health and Mental Hyg	giene
7	_		1 = State Registrar	Certificate of Death 2. Date of Dea	Reg. No. (U U / 14 J U
Q.	Physici		1. Decedent's Name (First, Middle, Last) Barbara Cunning	anam April	Day Year 3. Time of Death 345PM
6	/Medio		4a.¡Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Peath	4c Sounty of Death
			North west Hospital	Kandallstown	Paltimore
	Funeral		5. Social Security Number 220-68-5245 6. Sex 7 7. Age (In yrs. In the second security Number 52 52	Asst birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month), Days Hours Min. Feb. 11	9. Birthplace (State or Foreign Country) MD
H	Director		Usual Residence of Decedent	100. 11	7 1555
	arytan show d at	<u></u>		y, Town or Location Arnold	10d. Inside City Limits 1 ☐ Yes 2 X No
	the Ma 28a-f ootifie	ecto	MD Anne Arunde L 10e. Street and Number		10g. Citizen of What Country?
	be filed within 72 hours after death with the Maryland ttal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	789 Harmony Avenue	21012	USA
	er dea items	nue	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
336	urs aft al', or xami	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 1 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ANO Specify:	Specify: White
2-0	72 ho "natur dical l	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
21215-0036	l within giene. r than the Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Customer Service Rep	Naval Exchange
pui	tal d o	Be	17. Father's Name (First, Middle, Last) James B. Marshall	18. Mother's Name (First, Middle, Mildred R. Forr	,
Maryland	ges 1 and 2 should be f it of Health and Mental F if item 27 is marked or or other traumatic eve	2	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rural Route Numbe	er, City or Town, State, Zip Code)
	s 1 and 2 of Health a Item 27 is other trai		Aimee N. Simmons/Daughter	5525 Ashbourne Road, Baltimor	
Baltimore,	Pages 1 nent of H ant: If Iter ary or oth			Place of Disposition (Name of remetery, crematory or other place) Apr. 13,	20c. Location - City or Town, State Baltimore, MD
altin	- F P E		4 □ Donation 5 □ Other (Specify) 21. Signature of Filmeral Service Licensee/	2007	
ä	permii Depar Impor any Ir		2 Shoms FAll	Barranco & Sons, P.A. Seven 495 Gov. Ritchie Hwy, Seven	
			23a. Part . Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final		rest, Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence)		s days
	Examiner	L	Sequentially list conditions, b. Starhul	lococcus aureus Se	epsis weeks
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Jence of):	A.
Ö,	cate be executed ohysician and the burial-transit	Еха	resulting in death) Last Due to (or as a consequence of the control of the contro	uence of):	
38760,	ficate be executed physician and s the burial-transit	dical	d		
Box 6	leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnant		23d. Date of delivery
	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Month Day Year
, P.O.	res that the de signed by the a be detached t	by Phy		ulting in the underlying cause given in Part I. 23e. Did to	obacco use contribute to the cause of death?
Division or Vital Records,	w require been sig should b	ted b		1 D Y	es 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
3ec	e law l has be je 2 sh	Completed		24a, Was a autop	an 24b. Were autopsy findings available prior to completion of cause of death?
Ta F			25. Was case referred to medical		2 ¼No 1 ☐ Yes 2 ¼No
Ž	> .0 0	To Be	examiner?	ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Resid	
o u	Jing Ph		27. Manner of Death 28a. Date of Injury 1. Natural 5 □ Pending (Month, Day Year)	28b. Time of Injury at Work? 28d. Describe h	ow injury occurred
isio	I or Attendi after death. Director: A d in by the fu	icati	2 Accident investigation 3 Suicide 6 Could not be 388 Bloom of injury. At he	M 1 ☐ Yes 2 ☐ No ☐ Dome, farm, street, factory, office ☐ 28f. Location (S	Street and Number or Rural Route Number,
Div	al or A after a Direct d in by	Certification:	4 Homicide determined building, etc. (Specific	y) City or Tow	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical C		owledge, death occurred at the time, date and place, and due to the cation and/or investigation, in my opinion, death occurred at the time,	
	To the vithin To the comple	Mec	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			Churrene Kajuh Hos	>1 talist 62912	April 11200T
	3		Christine Review Research Christine Christine Review Research Review Research Review Research	Dld Court Road Randa	11 stown Maryland
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 6 2007		
DH	IMH 17 Rev 1/2		APR 1 6 2007 Kleen	J. Good	
				ORIGINAL	
					50 AC AC AC

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Salathiel Brooks Carlile April /Medical 16, 2007 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral 1**€M 2□F Months Days Director 214 56 0633 58 June 19, 1948 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location "natural", or Items 23a or 28a-f show dical Examiner must be notified at 10b County 10d. Inside City Limits 1 □Yes 2 No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7849 Americana Cir. 21060 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify: White 3 ☐ Widowed 4 ☐ Divorced 1973 Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 7 Is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Union Carpenter Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental H tem 27 Is marked oth Be James Carlile Betty Vandevender 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health ar Important: If Item 27 Is any injury or other trau Colleen F. Carlile/wife 7849 Americana Cir. T2 Glen Burnie, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 4/20/2007 Catonsville, MD 21. Signature of Funeral Service License M01442 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pk. - Ellicott City, MD 23a. Part1. Softer the disease, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter und rrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as 1 IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign be (Completed by 1 Yes 2 No 3 Probably 4 Vnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy page perform certificate 1□ Yes 2XNo Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2XNo 1

Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Hospital or Attending (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the hours after death uneral Director: 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 ☐ Homicide filled in within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 241 Free D45149 April 16, 2007 person w 30. Name and address of o completed cause of death (Item 23a) (Type, Print) 301 Hospital Dr. Onabojo, В. Glen Burnie, MD 21061 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** April 17 2007 8:39 Alfred Caiazzo AM /Medical 4b. City. Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) Examiner Catonsville Baltimore Frederick Villa Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Dec 27, 1911 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 12XM 2□ F New York Director 114 05 5976 95 Usuel Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Marylend Department of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural; or item 23a or 28a-f show any injury or other traumatic event, if a Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Director Howard MD Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 6500 Freetown Road Apt 332 21044 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify. Specify. þ 3 Widowed 4 □ Divorced White Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) US Postal Service Government Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Concetta Puglisi Anthony Caiazzo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5900 Abrianna Way Elkridge, MD 21075 Gaetan A. Caiazzo/Son 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. John's Cemetery 4+23-2007 Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical ardio muo Examiner buriel-trensit or Attending Physician: The lew requires that the daath certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as e consequence of): 23b. Dld tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Anknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed TO YES 210 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗖 🕄 No nours eftar death.

neral Director: After this y filled in by the funeral di After this 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Naturel 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide • Funeral Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner. On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospi within 24 hou To the Funer completely fil (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D47683 Rannord Miller 4/18/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reistostun MP Kunnery Miller 25 Main street Sink 200 32. Registrer's Signature 31. Date filed (Month, Day, Year) State APR 1 9 2007 Registrar

Division or Vital Records, P.O. Box 68760,

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR 2 3 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Registrar's Signature

29c. License number

D36206

Dr. Kiran Mehta

> Three

29d. Date signed (Month, Day, Year)

'sad, Hellywood MD

Division or Vital Records, P.O. Box 68760, signed by the attending physician

Hilda Conley 04 18 07 0220 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death WMHS-Braddock Campus Cumberland Allegany If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2X□ F 213-24-5371 March 17 1922 West Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturat", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at any Injury or other traumatic event, the Medical Examiner must be notifiled at 1 ☐ Yes 2 TNo MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 14106 Pinto Road, S.W. 21502 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗓 No ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Shepard Susan Sayers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl Conley, Son 14106 Pinto Road, S.W., Cumberland, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Kalbaugh Cemetery 4/21/07 Elk Garden, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 710 Church Street, Kitzmiller, MD 21538 Katreview Sweize 23a. Part1. Enter the disease, or complication. P at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DAYS disease or condition resulting in death) /Medical Examiner Seguentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-tran Due to (or as a consequence) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2XX No. autopsy performed? Yes 200 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, f. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 12 Lopatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1/D Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral L Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signat/The and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) m.D. P.O. BOX Sabahat Nawah 265, Grantsville, mp 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 200 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

3. Time of Death

07-03146 Agnes Crusev

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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ignes ordsey	1- For State Certificate Registrar		Reg. No.
Physician/	Decedent's Name (First, Middle,Last)	2. Date of Month	Day Year 10551
Medical Examiner	ngiics of deely	4b. City, Town, or Location of Death	24, 2007 1055 hrs 4c. County of Death
	4a. Facility Name (if not institution, give street and number) 3328 Oak Drive	Edgewater	Anne Arundel
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	'	of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	216-18-7008 1 M 2X F 84	Yrs. Months Days Hours Min. 07/	15/1922 Country Maryland
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d . Inside City Limits
*	Maryland Anne Arundel Edgewate		1 Yes 2 X No
Aaryland Aaryland 1 at once.	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3a or Otified	3328 Oak Drive	21037	United States
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et	s or No- 14. Race - American Indian, Black, c.) White, etc.
fter de I", or i In Pu	1 3 V WINDWAR 4 DIVORCED III 198, GIVE 1981	Yes 2 X No specify:	Specify: White
ours aft		edent's Usual Occupation (Give kind of work done ng most of working life. DO NOT use retired)	16b. Kind of Business/Industry
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Ho	memaker	Home
sd with ygiene other t	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, M	
1215 Ibe file arked or vent, t	Lee Adams	Agnes Crand	
D 21 should and Mei 7 is mai natic ev	, , , , , , , , , , , , , , , , , , , ,	failing Address (Street and Number or Rural Rou 17 S. Roling Road, Balt	
e, M and 2 Health item 2 traun	20a. Method of Disposition 20b. Place of D	isposition (Name of cemetery, Date	20c. Location - City or Town, State
more Pages 1 sent of 1 net: If r other	1 A Burial 2 Cremation 3 Removal from State	or other place) .dge Cemetery 04/30/2	007 Pikesville, Maryland
Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical To Be Comple	21. Signature of Funeral Service Licensee	22. Name and Address of Facility George P.	Kalas Funeral Home, P.A.
	23a. Part I. Enter the disease, or complications that caused the death. Do not e	2973 Solomons Island Road, E	dgewater, Maryland 2103/
Physician 'Medical	failure. List only one cause on each line.		Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Hy pertensive Cardiovas Due to (or as a consequence of):	egiai discase	
<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
ted Innsit	Causa. Enter Underlying Cause (Disease or injury that initiated C. Due to (or as a consequence of):		
urted ansit	events resulting in death) Last Due to (or as a consequence or). d.		
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Box 68760, death certificate be re attending physici of for use as the burivectory		Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
b. Box 687 the death certific the attending I ched for use as the	past 12 months? past 12 months? 4 Pregnant at time of death 5	Other (Specify)	
Bo he dear the dear hed for hed for hed for hed for hed for shows	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I 236	e. Did tobacco use contribute to the cause of death?
Division of Vital Records, P.O. Box 687 tall or Attending Physician: The law requires that the death certific and the death certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as the original to Re Commission by Physician	Demvelinating disease of central nervous		Yes 2 No 3 Probably 4 Unknown
Records, The law require. Ticate has been signage 2 should be		248	a. Was an 24b. Were autopsy findings available prior to completion of cause of
eco he law ate has		1	performed? death? Yes 2 No 1 Yes 2 No
al R ian: T certific ctor, p	25. Was case referred to medical	26.Place of Death (Check only one	
of Vita ing Physicia After this ce funeral direc	1 Yes 2 No 1 inpatient 2 EROULE	atient 3 DOA Other Nursing Home ne of Injury 28c. Injury at Work? 28d. De	5 Residence 6 Other: Scene
on Oil ading I th. : Afte e funer	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 X Natural 5 Pending	1 Yes 2 No	
ivisior I or Attendath after death Director:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm		cation (Street and Number or Rural Route Number, City Town, State)
Division of Vital Hospital or Attending Physician: 24 hours after death tehy filled in by the funeral director, tely filled in by the funeral director,	4 Homicide determined (Specify)		
2		occurred at the time, date and place, and due to t estigation, in my opinion, death occurred at the tim	the cause(s) and manner as stated. The date and place, and due to the cause(s)
To the Ho within 24 To the Fu completely	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Josho Fe of up	O.C.M.E.	April 25, 2007
,	30. Name and address of person who completed cause of death (Item 23a)	444 Danie Ob. 4 Dalli	
0	Tasha Greenberg MD. Assistant Medical Examiner 31. Date filed (Manth Day, Year). 32. Registrar's Signature	111 Penn Street, Baltimore, MD 2120	Л
Stat Registra	10/11 V 11 O 2007 28a 28	oul	

			For State Registrar	State of N	Marylar				lealth a			jiene	007		
1	Ange a	106	1. Decedent's Name (First, Middle, Las	st)							2. Date of Dea Month	th Day	Year	3. Time of Death	
	Physici /Medio		Lula Mary	Douglas							April 1	L1, 2		10:50p ^M	
).	Examir	er	4a. Facility Name (If not institution, give	street and number	er)				r Location o			4c. C	ounty of Death		
			Manor Care Si				1		Spri				Montg		
	Funeral:		5. Social Security Number 6. S	ex		last birthday) 36 Yrs.	Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day	(Year)		nplace (State or Foreign untry)	
la (m)	Director		579-20-9019	^^							Sept.30	, 192	O Ge	orgia	
	end w		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits	
	f sh	ρ	MD Monto	omery			Sil	ver :	Sprin	g				1X⊈XYes 2 □ No	
	17.28a	rec	10e. Street and Number				10f. Z	p Code			· · · · · · · · · · · · · · · · · · ·	10g. Citize	en of What Co	untry?	
	d within 72 hours after death with the Marylend Jisele. I then "natural", or items 23a or 28a-f show The Mudical Evail, for must be Lodified at	Funeral Director	1000 Brunswick	Avenue .	Apt.	#205		209	910		:	Unit	ed Sta	tes	
	ms 2	Jer	11. Marital Status	12. Was Decede		J.S. 13.	Was Dece	dent of H	ispanic Ori	igin? (Spe	crfy Yes or No- Rican, etc.)	14	Race - Amer		
9	or its	Ī	1 ☐ Never Married 2 ☐ Married	Armed Force 1 ☐ Yes 2 [If Yes, Give			iires, spi 1 ⊟ Yes		Specify:		nicari, etc.)		Black, White	rican-	
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S	TO TO be and		17. Father's Name (First, Middle, Last)			1111100	- y -	1000			(First, Middle,			V 1	
ano	b la b	Be c		xon					Lul		ıff				
2	should be ind Menta ind marked umatic ev	ဥ	19a, Informant's Name/Relationship	Type, Print)		19b. Mailir	na Addres	s (Street	and Numbe	er or Rura	l Route Numbe	r. City or	Town State, Z	in Code)	
Maryland	~ ~ ~		Joyce R. Richards	**	ce)	1300	-	_	Stree		Bowie, N				
ē,	s 1 and 3 if Health item 27 other tra		20a. Method of Disposition		20b. I	Place of Dispo cemetery, crer	sition (Na	me of	101	D	ate	20c. Loca	ation - City or	Town, State	
e E			1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi			xon Men				4/23	1/2007	Sp	arta,	GA	
Baltimore,	permit. Page Department of Important: If eny injury or ance.		21. Signature of Fune al Servide Licer			22	2. Name a	nd Addre	ss of Facilit	y McGı	ire Fu	neral	Servi	ce, Inc.	
ä	Ped F Ped		Undre	Tho	nasc	Jul 74	100 G	eorg	ia Av	enue	, NW, V	Washi	ngton :	DC 20012	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between												
	Physician		Immediate Cause (Final												
7	/Medical		disease or condition resulting in death)	aDue to (or	as a consec		, DI	east	Can	CET					
ж.	Examiner		O	b											
	A. L. V.	ner	Sequentially list conditions, and the sequence of the cause. Enter Underlying												
	cuted	Examiner	Cause (Disease or injury that initiated events	C.											
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68760	death certificate be executed e attending physician and nd for use as the burial-transit	lical		_ d.									_		
9	leath certifica attending ph for use as th	Me	IF FEMALE:												
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1 ☐ Live birth	2 Feta	al death 3 [pregnancy	,			23			
o.		Physician/Med	1 ☐ Yes 2√ No 9 ☐ Unknown	4□Pregnant 9□Unknowr		death 5∟	Other (s	pecify)						,	
Δ.	The law requires thet the ste hes been signed by th bage 2 should be detache	þ	Part II. Other significant conditions of	ontributing to death	but not res	sulting in the u	nderlvina	cause div	en in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?	
ds,	ulres n sign ld be			·	•		3	,	3			1 🗆 Y	es 2 🗍	No 3□Pro	obably 4. ★Unknown
Ö	v requ	ete									24a. Was a		24h Worn au	toony lindings available	
Record	The lav	Completed									autop:	sy	prior to c	completion of cause of	
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Vital		Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		75D(0		Oth	05		(Check only or				
o	Phys rthis raldi	. To	27. Manner of Death	28a. Date of In (Month, i		ER/Outpatier 28b. Time of		28c. Injur Wor	41_2JVU		ne 5 ∐ Hesid 28d. Describe h			cify)	
O	ding f th. : After s funera	ij	1 Naturat 5 Pending 2 Accident investigation		Day Year)	Injury	м		k? Yes 2 🔲	No	256. Describe now injury described				
Division	of or Attending after death. I Director: After din by the fune	fica	3 Suicide 6 Could not b	28e. Place of	Injury - At h	iome, farm, str	eet, facto	ry, office		2			Number or Ru	ral Route Number,	
Ö	를 걸 들	Certification:	4 Homicide determined	building,	etc."(Speci	<i>fy)</i>					City or Tow	n, State)			
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	To the Hos within 24 h To the Fun completely	Medical	(Check only 2 Medical Examone)	niner: On the basis and manner	s of examina stated.	ation and/or in	vestigatio	n, in my o	pinion, dea	ith occurre	ed at the time, o	late and p	lace, and due	to the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	111 1	1		25	c. Licens			i				
L	1		· land	Litte	2			005	3235			Apri	11 16,	2007	
	ŧ		30. Name and address of person who	completed cause of	of death (Ite	т 23а) (Туре,	Print)								
			Darryl A. Hil	-	136		ltimo	ore A	venue	, La	urel, M	Aryla	and 20	707	
0	Sta Regist		31. Date filed (Month, Day, Year)	Regi	strar's Sign	ature	WE								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Elizabeth S. Davis 4 18 07 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Coastal Hoppice At The Lake Salisbury WICOMICO 5. Social Security Number Under 1 Year | If Under 24 Hrs. onths | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 214-36-5416 68 NC Aug. 21, 1938 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 X No MD Wicomico Willards 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 36569 Three Bridges Rd. 21874 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nutritionist Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Jerome Simpson, Sr. Mary Meyers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lindy Davis (son) <u>35333 Cobbs Hill Rd., Willards, Md. 21874</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Perdue Cemetery 4-21-2007 Powellville, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 28a. Part1. Enter the disease, shock, or heart failure. List nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse vience of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending physician for use as the buria after death within 24 hours after To the Funeral Discompletely filled in

Physician

*/Medical

Examiner

Funeral Director

items 23a or 28a-f show

Medical Examiner must be notified at

Director

Funeral

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Completed

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Certification: To

Medical

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "nature" any injury or other traumatic any injury or other traumatic any injury.

Physician /Medical

resulting in death) Last	Due to (or as a consec	quence of):			
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of o	al death 3 Ectopic pro			23d. Date of delivery Month Day Year
Part II. Other significant conditions	1	ulting in the underlying ca	use given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
•				24a. Was an autopsy performed' 1 Yes 2	
25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)	
1 Yes 2 No	Hospital Inpatient 2	ER/Outpatient 3 DO	Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)
7. Manner of Teath Antural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	Bc. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, street, factory	office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
29a. Certifier (Check only one) Certifying Property one)	nysician: To the best of my knowniner: On the basis of examination and manner stated.	owledge, death occurred a ation and/or investigation,	at the time, date and place in my opinion, death occ	ce, and due to the cause curred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
Oh Dianatura and title of contiliar	2 -/	200	License number	1 00.11	3 1 1 1 1 1 1 1 5 1 1 1

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State Registrar 31. Date filed (Month, Day, APR 19

Carell.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		PI For State Registrar	ease Type o State			d / Depa		t of H	ealth a		I Copies lental Hy		e a a a	ble.	through a	and the same of th
Physicia		1. Decedent's Name (First, Maria Josephin		10		_					2. Date of Do Month April	eath Da	ay 2(Year 007	3. Time 1:4	of Death
/Medic Examin		4a. Facility Name (If not institu					4b. City,		Location o		-		c. County	of Death		
Funeral Director		5. Social Security Number 072–09–5753	6. Sex 1 ☐ M 23€		ge (In yrs. la 91	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bi (Month, Di December	ay, Year) 1915	Cot	place (State intry) York	or Foreign
Maryland -f show led at	tor	Usual Residence of Decedent 10a. State 10b. Cou Maryland 5	nty St. Mary's	}	10c. City	, Town or Lo		Leon	ardto	wn					10d. Inside	City Limits s 2 □ No
h with the 23a or 28a st be notif	Funeral Director	10e. Street and Number 22680 Cedar I	ane Court	Apt	. 105	i	10f. Zip		20650)		10g. C	itizen of V	What Cou	intry?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ ! 3 ☑ Widowed 4 □ Divor	Armed 1 ☐ Y If Yes	d Forces? es 2⊠			Was Deced If Yes, spec 1 ☐ Yes		spanic Ori n, Mexican Specify:	gin? (Sp i, Puerto	ecify Yes or No Rican, etc.)	0-	Blac	ce - Amer ck, White y: Wh:		
within 72 ho ene. than "natur he Medical I	Completed	15. Dece (Specify only hi Elementary/Secondary (0-1 12	dent's Education phest grade complet 2) Colleg	e <i>d)</i> je (1-4or	5+)	life. L	dent's Usua kind of wo DO NOT us tress	k done d	luring most	t of work	ing			usiness/li irant		
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Menta Menta arked	To B	Frank	Trapas	so					Eli	zabe	th			Mag1	io	
and 2 sho ealth and m 27 is me		19a. Informant's Name/Relate Joseph DeAnge			Loo. 5	59 Ha	anove	r PL		milt	on, OH	450	13			
t. Pages t tment of H tant: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Other	r (Specify)	om State	CE	lace of Dispo emetery, crer	natory or o	ther plac		Apri 2	1 25, 2007			-	New Y	ork
permit Depar Impor any In		21 Signature of Funeral Sen 23a. Part . Enter the disease	X Jaio	lini	2	Ma Le	onardt	ey-Ga own,	rdiner MD 206	Fune 50	eral Home		Α.		Approxim	-4-
Physician /Medical Examiner physician and physician and street physician and street physician and street physician street phy	dical Examiner	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	on each li	a ponseques a conseques a conseques	pente of):	is ps	ist.)						Interval B Ogset and	etween Death
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Physician: r this certificantal director,	o Be	25. Was case referred to me examiner? 1 ☐ Yes 2 ☐ No	Hospital:	I □ Inpati	ent 2 🗆 1	ER/Outpatien	nt 3 DC	Othe	er:		h <i>(Check only</i> ome 5 ☐ Res		6 🗆 Ott	ner /Sner	vifu)	
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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical ((Check only 2 Med one)	Δ.		of examinat		vestigation	, in my o	pinion, dea			e, date a	nd place,	and due	to the cause	
P P P P P	M	29b. Signature and title of de	son who completed				Print)	Jame	onumber Ob es P.	/4/ Jar	9 boe, M.	4	ate signe	23-	0, Day, Year)	
Sta Registr		24035 Three	Notch Rda 3 2007	Regist	rar's Signa			0636								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 20, Agnes Delozier Apri1 2007 10:19 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center Leonardtown

If Under 1 Year | If Under 24 Hrs. St. Mary's Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□M 2X F Hours Director 217-64-7725 89 10/07/1917 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hyglene. The marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Funeral Director Maryland | St. Mary's Leonardtown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23280 Greenbriar Road 20650 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. Completed by 3 XWidowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P William Alexander Morgan Caroline Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wayne Delozier/Son 23280 Greenbriar Road, Leonardtown, MD 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of I-Important: If ite any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/25/2007 | Leonardtown, Maryland Aloysius Cem. Funeral Service Ligenses 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) MONINE /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my saling day. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

25365 Point Lookout Road, Leonardtown, MD

20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

William D. Boyd II, M.D.

APR 2 4 2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2:00 PM **Physician** MARCH 31 2007 DONALD LEE DITTY, SR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 315 QUEENS COLONY HIGH ROAD STEVENSVILLE QUEEN ANNE'S Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** 1 ₹ M 2 □ F Months Days Hours Min. Director 50 NOVEMBER 30, 1956 MARYLAND 215-70-0828 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show 1 ☐ Yes 2 XNo Director MARYLAND QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 315 QUEENS COLONY HIGH ROAD 21666 by Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 MANUFACTURING MACHINIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f THEODORE R. DITTY, SR. ပ EMMA ANDERSON and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health aitem 27 l 315 QUEENS COLONY HIGH ROAD, STEVENSVILLE, MD 21666 DAWN DITTY/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 20a. Method of Disposition APRIL 4. permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 CHESAPEAKE CREMATION STEVENSVILLE, MARYLAND 21. Signature of Prin al Service Lic FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 Approximate Interval Between Onset and Death 23a. Part1. Enter the di shock, or heart fa Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unit rights Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons uence of): Examiner death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy 1 Live birth 2 Fetal death Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco-use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed cate has been s , page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 21 No 1 ☐ Yes 1□ Yes or Attending Physician: 25. Was case referred to nedical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 ☐ Yes 1 Inpatient ဥ 2 ☐ ER/Outpatient 3∏ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Injury 1 - Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

APR 03 DHMH 17 Rev 1/2001

Curtis 31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Day, Year)

300

ORIGINAL

ed str 300 Annapolis

			For State Registrar	State of	f Marylar		artment rtificate			and M		iene 0 0 7	14149
			1. Decedent's Name (First, Middle	, Last)							2. Date of Dea		3. Time of Death
	Physicia		Evelyn Lee	Dear	1						April 2	22, 2007 Year	1:15 A M
	/Medic Examin		4a. Facility Name (If not institution	, give street and nu	mber)		4b. City,	Town, or	Location o			4c. County of Deat	h
	LXQ,IIII	ý.	Garrett County	Memoria]	Hospit	:a1	0a	k1an	d			Garre	tt
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		II Under	1 Year	If Under 2		8. Date of Birth	9 Bird	hplace (State or Foreign
	Director		213-84-3357	1□M 2XF	54	Yrs.	Months	Days	Hours	Min. S	(Month, Day, Sept. 23	, 1952 Mar	yland
Н	<u> </u>		Usual Residence of Decedent										
	nylar show	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	Sa-fs	9	MD Gar	rett			0akla	nd					1 ☐ Yes 2 X No
	1 or 2	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of What Co	ountry?
	death with the Maryland ms 23e or 28a-f show	<u>a</u>	1401 Broadford	Road					2155			USA	
	r deg	Funeral	11. Marital Status	Armed F		I.S. 13.	Was Deced If Yes, spec	ent of His	spanic Orig	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
9	or it		1 Never Married 2 Marr.	If Yas, G	VA	1	1 ☐ Yes 2		Specify:			Specify: 17	1. *
3-003p	urel:	d by	3 Widowed 4 Divorced	Year or [ates:	1 10 0						W	hite
ဂ်	"net	Completed	15. Decedent (Specify only highes	's Education t grade completed)		16a. Dece	dent's Usua kind of wor DO NOT us	k done d	tion uring most	of workin	g	16b. Kind of Business	Industry
7	withir	Ę.	Elementary/Secondary (0-12)	College (1-4or 5+)	1110.						None	
7	iled Hygie Ither nt, II		17. Father's Name (First, Middle,	asti		1	IN	one	18 Mothe	r's Name	(First Middle I	Maiden Sumame)	
yland	ntal I	Be		Neal	Dean								
Ž	hould d Me mark matic	2	19a. Informant's Name/Relationsi		Dean	19h Mailir	ag Address	(Street a		argar		, City or Town, State.	eese Zin Codel
Z Z	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Be perturent of Health and Mental Hygiene. I the mary is marked to ther then "neturel", or items 21s or 28s-1 show eny injury or other treumatic event, the Marileal Examination with the inclining all once.		Dianne Dean-An		ictor						nd, Mar		
a) L	1 and 2 Health em 27 i	- 1	20a. Method of Disposition	derson, s	20b. l	Place of Dispo	sition (Nam	e of				yland 215 20c. Location - City or	
Ď	ages to to i. if it		1 XBurial 2 ☐ Cremation		State	cemetery, crer				1001			
aitimore	it. Partmer rtmer rtent		4 ☐ Donation 5 ☐ Other (S)	- A	Gai	rett C	O. Me					Oakland, M	
g n	Depa Impo eny ir		21. Signature of Funeral Agrices	Consee		1						S. Second	
_			OSa Barti Fator the disease of	LAXONA)	anused the dee		tewar						21550
			23a. Part1. Enter the disease or shock, or heart failure. List	only one cause on	ach line.	in. Do not ent	er the mode	or dying	, such as	cardiac or	respiratory arr	est,	Approximate Interval Between Onset and Death
ı	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a	trute		Srun	oh	145				506 5
	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):		_					years
		_	Sequentially list conditions,	b. — Due to	Cu/	My S	em	er 6					4000
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Z Due to	(01 as a consec	(derice or).							/
	and and Il-trar	xan	that initiated events resulting in death) Last	c	(or as a consec	uence of):							
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ά	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	dicai		d									
٥ ×	certif ding se as	Physician/Me	IF FEMALE:	23c. If yes, ou	tcome of pregn	ancv						22d Date of del	
X Q Q	death e atten ed for u	lan	23b. Was decedent pregnant in the past 12 months?	1 Live	oirth 2 Feta	al death 3	Ectopic pre					23d. Date of del Month	Day Year
j	he de	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unkr		Jean J	1 Other (spe	-Ciry)					
7	requires that the		Part II. Dther significant condition	ns contributing to c	eath but not res	sulting in the u	nderlying ca	use give	n in Part I.		23e. Did tol	bacco use contribute to	the cause of death?
ds	sign d be	d by									1 □ Ye	es 2 No 3 Pr	obably 4 Danknown
ecords	v req	ete									24a. Was a	24h Wara a	itopsy findings available
ě	S 53 C3	Completed									autops	y e prior to	completion of cause of
	n: The licate he										1 ☐ Yes	2 □ No 1 □ Yes	2 No
VItal	certif recto	Be	25. Was case referred to medical examiner?	Hospital: (Othe	~		(Check only on		
ō	Phys this ral di	. To	1 Yes 20 No 27. Manner of Death	28a. Date		ER/Outpatier 28b. Time of		A	4 🔲 Nu			ence 6 Other (Specow injury occurred	cify)
	ding After fune	lon	1 ØNatural 5 ☐ Pendin	g (Mor	th, Day Year)	Injury	м	Bc. Injury Work	? es 2□↑		04. 00301100 110	ow injury occurred	
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UNISION	or A after Dire	Certification;	4 Homicide determ	build	ing, etc. (Speci	fy)	001, 1201019	, 011100			City or Town	n, State)	
	pitel purs erel filled		29a, Certifier 1 Certifyin	g Physician: To the	a hest of my kni	wledge death	o occurred a	at the time	a data and	d place, at	nd due to the co	ause(s) and manner as	stated
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medice!	Examiner : On the b	asis of examination of the state of the stat	ation and/or in	vestigation,	in my op	inion, deat	h occurre	d at the time, d	ate and place, and due	to the cause(s)
	o the	Me	29b. Signature and title of certifier				29c.	License	number		2	9d. Date signed (Monta	h, Day, Year)
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			30. Name and address of person	who completed a	on of door 1/11-	n 22e\ /T =	Drin*\						
		3	Dr. Robert Gora					St	() p 1, 1	and	Maryla:	nd 21550	
	Sta		31. Date filed (Month, Day, Year)		Begistrar's Signa		OF PIT	76.9	Jaki	and,	rial ATG	ng 21330	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** APRIL 13, 2007 Μ. FITZGERALD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SILVER SPRING
If Under 1 Year If Under 24 Hrs. MONTGOMERY FAIRLAND NURSING HOME 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5 Social Security Number **Funeral** Days Hours Months 1 □ M 2 🖫 F OCTOBER 16, 1915 TENNESSEE Director 91 408-38-4956 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director SILVER SPRING MARYLAND MONTGOMERY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 U.S.A. 12917 OLIVINE WAY Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Maryland 21215-0036 'natural", or Specify: þ 3 ☑ Widowed 4 ☐ Divorced Year or Dates: BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hyg
Important: If Item 27 is marked other
any injury or other traumatic event; 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN BRAZELTON **LAURA** 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12917 OLIVINE WAY, SILVER SPRING, MARYLAND 20904 ANDREA FITZGERALD/DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KNOXVILLE, TENNESSEE HIGHLAND MEMORIAL PARK 4/19/2007 21. Signature of Funeral Service License 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC SPRING, MARYLAND 20904 SILVER 11800 NEW HAMPSHIRE AVENUE, Approximate Interval Between Onset and Death ations that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) neumoure **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 4 ☐ Pregnant at time of death the 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 → No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 certificate has 1□ Yes 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Other: 4 Vursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 2 1 ☐ Yes After this 27. Manner of Death 1 [DNatural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760, P.O. Records, Division or Vital

death. To the Hospital or Attent within 24 hours after death To the Funeral Director: filled in by

Certification: Medical

4 ☐ Homicide

29a. Certifier

29b. Signature a

31. Date filed (Month, Day, Year)

APR

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHASHANK G. PATEL, M.D.,

18

2007

32. Registrar's Signature

2309 SHOREFIELD ROAD, WHEATON, MARYLAND 20902

I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

29d. Date signed (Month, Day, Year)

007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Evelyn Janet Friedel 4/13/2007 11:35 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2828 Pennypond Lane Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) 12/8/1932 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 X F 74 Director Maryland 212-30-1394 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10h County 10d. Inside City Limits 28a-f show other traumatic event, the M-dical Examiner must be notified at 1 ☐ Yes 2XXXVo Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Int: If Item 27 Is marked other than "natural", or Items 23a or 2828 Pennypond Lane 21401 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ŽŽNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify White 2 3 Widowed XX Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Analyst State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Flemon Stockett 2 Mary Frances Marshall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other trains 2828 Pennypond Lane Annapolis, MD 21401

ace of Disposition (Name of Date 20c. Location - City or Town, State John A. Friedel 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial XXCremation 3 ☐ Removal from State Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 4/16/2007 Baltimore, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service License alad 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disshock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CIONCIEN **Physician** mos disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) within 24 hours after uean...

To the Funeral Director: After the function of 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Registrar APR 1 7 2

31. Date filed (Month, Day, Year)

MULTY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Parmaners mo 2 1407

			1 - For State Registrar			artment of rtificate or			eg. No.	07		152
	Physici	an	1. Decedent's Name (First, Middle, Las	•				2. Date of Deal Month	Day	Year		of Death
	/Medic		RUTH KATHERINE 4a. Facility Name (If not institution, give	Street and number)		4h Cily Town	, or Location of D	APRIL		2007 nty of Death		30 P ^M
	Examir	ier	212 EDENDERR				TREVILLE			EEN A		
	Funeral Director		5. Social Security Number 6. Sec. 176–26–8660		n yrs. last birthday) Yrs.		r If Under 24		Year)	9. Birth		e or Foreign
	and W		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation					10d. Inside	City Limits
	Mary Find	to	MD QUEEN	ANNE	CENTRI	EVILLE						es 2 No
	or 286	Director	10e. Street and Number	1		10f. Zip Code		1	0g. Citizen o	of What Cou	untry?	
	am w	ral	212 EDENDERRY A				1617		US	A		
950	De lided within 72 hours after death with the Maryland half Hygiene. Ad other than "naturel", or iteme 23e or 28e-f show event, the Madical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:	1	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2X N		? (Specify Yes or No- Puerto Rican, etc.)		lack, White	ican Indian, , etc. HITE	,
ָ ה	natur	eted	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dece	dent's Usual Occ	upation	l working	16b. Kind of	Business/I	ndustry	
V :	P 9 9	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use reti	red)		कटा हर	HOME	COMD A	MTV'
V -	e rited within al Hygiene. i other than vent, ibe We	e Co	12 17. Father's Name (First, Middle, Last)	-0-	Gu	STOMER S		Name (First, Middle, I	TELEP		COMPA	N I
Ξ.	e d al	To Be	ALFRED McCULLOH 19a. Informant's Name/Relationship (7)				KAT	THERINE WHI	LSTING			
\$	har har 7 ie treu		DENISE GRUIN/ GR	,, ,				CENTREVILI	. ,		,,	
ָב פֿר	of Hee		20a. Method of Disposition		20b. Place of Dispo	osition (Name of	lace)	Date	20c. Location			
Ĕ	rages ment of I ent: If Its ury or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		CHESAPEA	KE CREMA	TION 4-	-5-2007	STEVEN	SVILL	E, MD	
	permit. Pages 1 and Deportment of Heeli Importent: if item 2 any njury or other 2005.		21. Signature of Funeral Service Licen	500	F	2. Name and Add ELLOWS, H 08 S. LI	ELFENBE	IN & NEWNAI	M FUNE TREVIL	RAL B	ЮМЕ, D 216	P.A.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications at crused the ne cause on each line.							Approxim	nate Between
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	/Medical Examiner	н	f	Due to (or as a co							1.1. "	
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٠ ۲	death certifica ettending phy of or use es th	/Med	IF FEMALE:	23c. If yes, outcome of p	regnancy				204.6	N.A		
5	ine death by the etter ached for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ②No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnan Other (specify)	ncy			Date of deliver of the state of	Day	Year
ords, r	To the Propriet of Attending Prysicient: The law requires that the death certificate be executed within the contribution of the contribution of the contribution and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Ď	Part II. Other significant conditions of	ntributing to death but n	ot resulting in the u	inderlying cause g	given in Part I.	23e. Did tol	acco use co		the cause of	
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V 110	certific	Be	25. Was case referred to medical examiner?	Hospital:		10	thos	Death Check only on	θ)			
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=	efter des Offrector of in by th	Certifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	At home, farm, str Specify)	reet, factory, office	9	28f. Location (St City or Town		nber or Rui	ral Route N	umber,
	ine hospital	dlcal	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	rsician: To the best of miner: On the basis of example and manner stated	amination and/or in	h occurred at the vestigation, in my	time, date and p	place, and due to the ca occurred at the time, d	ause(s) and rate and place	manner as	stated. to the cause	e(s)
-	To thin	Me	29b. Signature and title of certifier	(29c. Licer	nse number	2	9d. Date sign	ned (Month,	Day, Year)
/	P		1/ Wargant	15/Valar	d mo	Do	05512	7	4/4	107	,	
	4 /		30. Name and address of person who of Margaret (). Male	ompleted cause of death	(Item 23a) (Type, 5 Sallitt	Print) Drive	Stevensv	rille, MD	2166	6		
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 5 20	32. Registrar's	Signature	narte			,			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month April 16, 2007 P^{M} Mary A. Gerde 1:10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Collingswood Nursing Center Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 567-07-7196 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 88 1 M 2 XF May 11, 1918 Massachusetts Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Gaithersburg 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9104 Rosemont Drive 20877 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1⊠Yes 2□No World If Yes, Give Year or Dates:War II 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant United Way 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Leedy Vera Barber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice R. Gerde (Daughter) P.O. Box 564 Ft. Meade, MD 20755 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 4/17/07 Alexandria, Virginia 22 Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Funeral Service 23a. Part Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each the complete of the cause on each the complete of the cause on each the cause of the Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition

To the Hospital or Attending Physician: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760 attending physician for use as the buria within 24 hours aner com.

To the Funeral Director: Af

Re Completed Madical Cartification

Physician

Examiner

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show am purjury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical Examiner

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

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10a. State

h	Due to (or as a consequence of):	
Sequentially list conditions, and any cause. Enter Underlying Cause (Disease or injury that initiated events	Eue to for as a consequence of):	
resulting in death) Last	Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3C. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions cont	tributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
	~	24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 2 No 24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical examiner?	26. Place of Death (
1 Yes 2 No	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home	e 5 Residence 6 Other (Specify)
1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No	id. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1. Certifying Physi (Check only one) 2 ☐ Medical Examin	ician: To the best of my knowledge, death occurred at the time, date and place, arer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause(s) and manner as stated. If at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	14 och MD 29c. License number D0062435	29d. Date signed (Month, Day, Year) 4/6/0-7
30. Name and address of person who con	mpleted cause of death (Item 23a) (Type, Print) 9715 Medile lente B. Rock	cuille, MD 20850

State Registrar

SAYED EISAYTAL 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deat 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Patricia Lynn Gannon April 29, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ji VISTA Charles MEdical enter lata Year) 14, 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days 1 ☐ M 2 🖫 F 212-68-1951 51 Maryland September 1955 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland St. Mary's Directo Mechanicsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 30013 Oak Acres Drive 20659 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NOUL AL Rudolph Jackson Kunowsky Mary Lou Renn ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30013 Oak Acres Dr., Mechanicsville, MD 20659 19a. Informant's Name/Relationship (Type. Print) Christopher Gannon/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation April 26. 3 ☐Removal from State Queen of Peace Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Mechanicsville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Brinsfield-Echols Funeral Home, P.A., 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one round on each line. Immediate Cause (Final VDOCHOTT **Physician** * WEEKS EPLY CHUNENT disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner to (or as a consequence if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: use 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown detached 9□Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe certificate 1∐ Yes 2 🕅 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ★ ER/Outpatient 3 ☐ DOA ٩ 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? Injury (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type 11345 Pembrooke Square EOYGE WATHEN M.D. Suite 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death o^{Year} 1. Decedent's Name (First, Middle, Last) 2. Date of Death 23^{Day} **Physician** Thelma 04 М Grove 0448 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WMHS-Braddock Campus Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Year Months Days 1 □ M 2**X** F Hours 217-18-4019 85 March 27, 1922 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a, State 10b. County 1 ☐ Yes 2 X No Directo MD Friendsville Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 must be n Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene. 1459 Mill Run Rd. 21531 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. I ☐ Yes 2 🔀 No f Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 XNo Specify 3 Widowed 4 Divorced White Year or Dates: er than "natur the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **1**2 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked c ၉ A. Donald Frazee Orpha B. Fike 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is other tra Floyd E. Grove/Husband 1459 Mill Run Rd., Friendsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 20c. Location - City or Town, State = 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department or Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Addison Cemetery April 26, 2007 Addison, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. De Z P.O. Box 275, Grantsville, MD Olman 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical s a consequence of): Examiner Coli Bacteremia scherichia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Infection Tract To the Hospital or Attending Physician: The law requires that the death certificate be executed rinary attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown signed by tl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2X No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an Were autopsy findings available prior to completion of cause of certificate has the autopsy perform death?
1 ☐ Yes 2 □ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

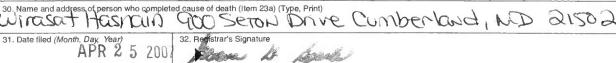
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

within 24 hours after death

To the Funeral Director:
completely filled in by the i

State Registrar 31. Date filed (Month, Day, Year) APR 2

29b. Signature and the of certifier



29c. License number

29d. Date signed (Month, Day, Year)

07-03040
Bruce Hillard
Phys
Modical Ex

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

race i illiara		- For State Certificate of Death		eg. No. 201	1 4 5
Physician/	1	. Decedent's Name (First, Middle,Last)	2. Date of Dea Month		3. Time of Death
Medical Examine		Bruce Hilliard	Month April 20, 2	2007 4c. County of Death	2114 hrs
	4	As. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George Hospital Center Cheverly		Prince George	
Funeral	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	8. Date of Bi		thplace (State or
Director		ukn 1X M 2 F 52 Yrs. Months Days Hours Min		3,1954 Foreign	^{untry)} SC
	\vdash	Usual Residence of Decedent	nug.	<u> </u>	
v any	1	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 X Yes 2 No
land f show	<u>:</u> L	DC Washington		O OTTO A TANK A CO	
the Maryland nor 28a-f sh	1	10e. Street and Number 10f. Zip Code		0g. Citizen of What Cou	
with the Maryland s 23a or 28a-f sho		331 K Street, NE 20002 11. Merital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.	necify Yes or No	United St	cates ican Indian, Black,
or items 23		1 Never Married 2 Married Armed Forces? Armed Forces? I Yes 2 No	Rican, etc.)	White, etc.	
safter d		3 Widowed 4 Divorced If Yes, Give Year or Dates:		Specify: Bla	
nours naturalizami		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of volume for during most of working life. DO NOT use retired to the complete of		16b. Kind of Business/	Industry
5-0036 ed within 72 hour lygiene, other than "natu he Medical Exar Completed		Elementary/Secondary (0-12) College (1-4 or 5+) 2 Entrepreneur		Priva	ata
d with	1		e (First, Middle,	Maiden Surname)	100
215 be file htal H- rked o ent, tl	3	Walter Hilliard Elouis	se Bro		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	2 [19a. Informant's Name/Relationship (Type, Print) Elouise Hilliard/mother 331 K Street, NE Washington, DC 2		mber, City or Town, State	e, Zip Code)
, ME and 2 s ealth a em 27 traum	_	Elouise Hilliard/mother Washington DC 20a. Method of Disposition (Name of cemetery,	20002 Date	20c. Location - City o	Town, State
nore ages 1 a nt of H nt: If it		1 Burial 2 Cremation 3 Removal from State crematory or other place)	100/07	Tandana	
- E 2 °		4 Donation 5 Other Specify: Harmony Mem. Park 4 / 2 Signature of Funeral Service Licensee 22. Name and Address of Facility HC	dges 8	Landovel & Edwards	F.H.
Balt permit Depart Impor injury	Y	sance Celevaces 3910 Silver Hil	ll Rd.	, Suitland	d,Md.20746
Physician	j	Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and
/Medical; ;aminer		Immediate Cause (Final disease or condition resulting in death) True to (or as a consequence of):	disease		Death
	1	h -			
190		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
ted killingit		Cisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
760, Édicate be executed into the burial - transit into burial - t	<u>}</u>	d			
60, ate be executory by sician and the burial - transment of the burial - transmedical		WENDED #23a,27, perME, g867,5/3/07 TT			
376(ificate ificate g phy:		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live hirth 2 Fetal death 3 Ectopic pregnancy	ancy	23d. Date of delive Month	ry Day Year
Box 687 re death certificate the attending properties as the foruse as the bresician/I	2	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			
D. Bo the dear by the arached fo	٤,	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did	tobacco use contribute to	the cause of death?
P.O.	2	Part II. Other Significant conditions Conditioning to death but not resulting in the orderlying cause given in rare.		es 2 No 3 Pro	_
Records, The law requires ficate has been signage 2 should be	3		24a. Was		utopsy findings available
COL law r law r has b e 2 sh				ormed? death?	completion of cause of
I Re		25. Was case referred to medical 26.Place of Death (Check	1 Yes	2 10 1	es 2 No
Vital ysician his cert directo	Ĭ	eyeminer?	ing Home 5	Residence 6 Oth	er:
of of ng Ph	T	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe	how injury occurred	
ttendi death. y the f	<u></u>	2 Accident Investigation		10	De la Maria de Oli
Division c spital or Attending nours after death. neral Director: Af filled in by the fun	<u> </u>	3 Suicide 6 Could not be determined (Specify)	or Town,		tural Route Number, City
Lospits 4 hours inners inners in Co	֡֟֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	4 Homicide 29a. Certifier 1 Contificion Physician: To the heat of my knowledge, death occurred at the time, date and place, and	d due to the car	use(s) and manner as sta	ited.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Functual Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	5	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, dat	e and place, and due to t	he cause(s)
F W F OO	1	29b. Signature and title of certifier 29c. License number		29d. Date signed (M	onth, Day, Year)
		Janie Jeey Min O.C.M.E.		April 21, 2007	
à		30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, M	ID 21201		
Stat			1201		
Stat Registra	5	31. Date filed (North, Pay Year) 2007			

			For State Registrar	State	of Marylan		artment of H tificate of L	lealth and M Death		iene g. No. 20 (7 14157
	/sicia ledica		1. Decedent's Name <i>(First, Middle,</i> Pau	ıl L. Hef	fner				2. Date of Deat Apherin 2	,Day2007	7ear 3. Time of Death 5:25 AM M
	amine		4a. Facility Name (If not institution, Northampton Ma				4b. City, Town, or Frederic	Location of Death		4c. County of Freder	Death
Fune Direc			212-24-7119	6. Sex 1XIM 2□ F	7. Age (In yrs. 7 8	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 6 / 2 6 / 1	Year)	9. Birthplace (State or Foreign Country) M D
// Aaryland	edat	Ī	Usual Residence of Decedent 10a. State 10b. County	erick		y, Town or Loc					10d. Inside City Limits 1
with the Na or 28a-	De notifi	Director	MD Fred 10e. Street and Number 10734 Stull R		<u>T</u>	reder	10f. Zip Code 2 1 7 0 1	1	10	g. Citizen of Wh	at Country?
21213-UU36 d within 72 hours after death with the Maryland sjene. r then "instural" or items 23a or 28a-f show	aminer mus	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	12. Was Dec Armed F	edent Ever in U. orces? 2 No ive Dates: 5 2 - 5		Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp. in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race -	American Indian, White, etc.
VIZIS-0036 within 72 hours at ene. than "natural", or	Medical Ex	Completed b	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education grade completed,		16a. Deced (Give I life. L		during most of work)	ing	16b. Kind of Busi	
be filed that the property of other	event,	Ř	8 17. Father's Name (<i>First, Middle, L</i> Walter Luther			1	Mechanio	18. Mother's Name	e (First, Middle, N	,	
2 m = 2	orner traumatic	<u>•</u>	19a. Informant's Name/Relationsh Verna Heffne	p (Type. Print)	Wife	T		Bessie and Number or Rum k Rd Mt	al Route Number,	City or Town, St	
altimore, IV rmit. Pages 1 and 2 partment of Health portant: If Item 27	ry or othe		20a. Method of Disposition 1 ☐ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	3 □Removal from	State 20b. P	lace of Dispos emetery, crem	sition (Name of natory or other plac		Date 2	20c. Location - Ci	ity or Town, State
baltimore permit. Pages 1 Department of H Important: If Ite	any inju		21. Signarure of Fun Service L	icerue	M0025	22		Bastore Church St			
Physici /Medi Examir	cal		23a. Part 1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on	each line. REN (or as a consequ	AL F	PAILURE				Approximate Interval Between Onset and Death
Sourced A	iai-transit	Ĭ	Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequ	uence of):	- CANDIO	om xuc	The DIST	ASB.	Yhnas.
BOX of Bath certifications attending	Tor use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	itcome pf pregna birth 2 □ Fetal nant at time of do	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
quires that an signed b		2	Part II. Other significant condition		leath but not resu	ulting in the un	derlying cause give	en in Part I.		_	ute to the cause of death?
The law	, page z sno	Completed							24a. Was an autopsy perform 1 Yes 2	/ prid	ere autopsy findings available or to completion of cause of ath?
Phys r this	meral director	on: Io Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date		ER/Outpatient 28b. Time of Injury	3 DOA Othe	4 LI Nursing Ho	me 5 Resider 28d. Describe hor	nce 6 Other	
LIVISION al or Attending a after death. Il Director: After	or in by the in	Certification:	2 Accident investige 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Plac	e of injury - At ho ling, etc. <i>(Specif</i> y	me, farm, stre	2011	Yes 2□No	28f. Location (Str City or Town,	eet and Number State)	or Rural Route Number,
the Hospita in 24 hours the Funera	pietery illie	Medical	(Check only 2 Medical E	xaminer: On the l	e best of my know pasis of examinat oner stated.	wledge, death tion and/or inv	estigation, in my op		and due to the ca red at the time, da	use(s) and manr ite and place, an	ner as stated. d due to the cause(s)
To t To t	100		29b. Signature and title of confifer	m_		MD		6499		d. Date signed (April 25	Month, Day, Year) 5, 2007
26			30. Name and address of person we Ronald E. Mil 31. Date filed (Month, Day, Year)	ler M.D	4 C.11	1we11	Drive N	Mt. Airy	, MD	21771	
Reg	State gistra	-	31. Date filed (Month, Day, Year) MAY 0 2 2	007	un di	Los	le				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** RICHARD LEE HOOVER SR APRIL P M 2007 4:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 2□F 185-30-2673 Director 1937 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 'natural", or items 23a or 28a-f show dical Examiner must be notifiled at Frederick Yes 2□No Maryland Frederick Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1807 Willow Creek Court 21702 United States permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) insurance agent insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be J. Aaron Hoover Anna Rhodes ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Hoover / wife 1807 Willow Creek Court FRederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State April 28, 1 Burial 2 □ Cremation 3 □ Removal from State Grace UCC Cemetery Taneytown, Maryland 4 Donation 5 Other (Specify) 2007 22. Name and Address of Facility Skiles Funeral Home 21. Signature of Juneral Service Licensee 136 East Baltimore Street Taneytown, Md. 21787 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute 1 Day myocar dias /Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Day Year 5 Other (specify) been signed by the s should be detached it 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes Disease arden 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has perton page 2 autopsy perform death? 1 ☐ Yes 2 X No 2 No 25. Was case referred to medical examiner? Stive head or Attending Physician: funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🔊 No Certification: To 1 Inpatient 2K ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After (Month, Day Year) Natural 2 Accident Injury 5 Pending investigation 1 ∏Yes 2 ∏No death. the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

V State Registrar (Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hanson

hama 0 2 2007

DHMH 17 Rev 1/2001

the

29c. License number

D5/643 Hiren Shah, M.D.

tredenick mp

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Heverly, Clement 1/20 2007 ADV. 07 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospita Harbor If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F 149-24-8091 Director 75 Sep. 3, 1931 PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural" ~ " any injury or other traumatic event and any injury or other event and any injury or 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 ☐ Yes 2 No **Funeral Director** MD Anne Arundel Arnold 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 129 Cresston Road 21012 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 10F 11. Marital Status Black, White, etc. 1955 1X Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 No White 1 ☐ Yes 2 No Specify: 1957 Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Organist Sacred Music 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clement F. Heverly, Jr. Evelyn Salvadore ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marilou Heverly/Wife 129 Cresston Road, Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ★Burial 2 Cremation 3 Removal from State Apr. Crownsville, MD MD Veterans Cemetery 2007 4 □ Donation 5 □ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home Euneral Service 495 Gov. Ritchie Hwy, Severna Park, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Electrical Activity (unknown cause) Pulseless Physician /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Dyslipidemia burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Š Dementio 3 Probably 4 ☑ Unknown 1 🗌 Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2□No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 → Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State

31. Date filed (Month, Day, Year) APR 17

MAY ALATTAR

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001) S. HANOVER ST. , BALTIMORE, MD HARBOR HOSPITAL 32. Ragistrar's Signature

Registrar

RES

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04,13,2007

			For State Registrar	State of Maryla		artment of H			iene 0 0 7	14160
	* 18		Decedent's Name (First, Middle, Last)					2. Date of Death	h Day Year	3. Time of Death
	Physicia /Medic		Richard J. Hoban					April	13, 200	
	Examin	er	4a. Facility Name (If not institution, give stre			4b. City, Town, or		th	4c. County of Dea	
		3,5	Home Sweet Home Ass. 5. Social Security Number 6. Sex		19 rs. last birthday)	Severn	na Park	8. Date of Birth	Anne A	
	Funeral Director		,	2□F	86 Yrs.	Months Days	Hours Min	(Month, Day,	1920	thplace (State or Foreign puntry)
2	D		Usual Residence of Decedent							
	show	J.	10a. State 10b. County MD Anne Arune		City, Town or Lo		rna Parl	c		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	Director	10e. Street and Number			10f. Zip Code			0g. Citizen of What C	
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show disal Examinational be molified a	Ī	515 Jumpers Hole	Road			1146		•	SA
	death ms 2	Funeral	11. Marital Status 12.	Was Decedent Ever in	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Specify Yes or No-	14. Race - Ame	
9	after or Its		1 Never Married 2 Marned	Armed Forces? 1 X Yes 2 □ No If Yes, Give		1 ☐ Yes 2X No		no man, etc.)	Black, Whi	White
21215-0036	ural',	d by	3 XWidowed 4 □ Divorced	Year or Dates: W	WII					Bardon American
15	n 72 nat	Completed	15. Decedent's Educat (Specify only highest grade of	ompleted)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of we	orking	16b. Kind of Business	vindustry
712	withi iene. r than	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	1	J.S. Army			Milit	ary
br	e filed al Hyg othe vent.	BeC	17. Father's Name (First, Middle, Last)					ıme (First, Middle, A		
<u>la</u>	Menta	10 8	Lawrence Hoban				Fern !	reetsworth	h	
Maryland	2 sho		19a. Informant's Name/Relationship (Type		1	-			City or Town, State,	
as	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event. It is Medical Examinar must be multified at	-	Susan Hoban/Daugh		. Place of Disp	osition (Name of		Date	a Park, MD 20c.Location-City or	
altimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		1 ☐ Burial 2 🖾 Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	anyal from State	cemetery, cre	matory or other plac rematory	Apr	. 14	Baltimore,	
ij	nit. Partme		21. Signature of Fun val Service Cicensee	,	2	2. Name and Addres	ss of Facility		rna Dark E	uneral Home
ä	Depa Depa Impo any ir		John (1)	tu	4	95 Gov. R	itchie	Hwy, Seven	rna Park,	MD 21146
ýr.	e st .		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the decause on each line.	eath. Do not en	ter the mode of dyin	g, such as cardia	ac or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		cord	ial	infar	hon		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as ons	sequence of):		1		2.4000	0
-1	1. The	9	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	sequence on:					
	uted d ansit	Examine	Cause (Disease or injury							
oʻ	exection and and rial-tra		resulting in death) Last	Due to (or as a cons	sequence of):					
8760,	death certificate be executed e attending physicien and ind for use as the burial-transit	edicai	d							
9	death certifica attending ph d for use as th	/Med	IF FEMALE:	If you gutcome of area	202004		1485			
Вох	attend for us	Physician/M	in the past 12 months?	. If yes, outcome of pred 1 Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
P.O.		ysic	1 ☐ Yes 2 No 9 ☐ Unknown	9 Unknown	7 404111 51					
	res that the igned by th be detache	by Pt	Part II. Dther significant conditions contri	buting to death but not	resulting in the u	ınderlying cause giv	en in Part I.	23e. Did tob	pacco use contribute t	o the cause of death?
rds	= 0, 10		Cardiomyopa	this				1 □ Ye	as 2 No 3 □ P	robabły 4 🗔 Unknown
eco	as b	Completed	Coronary a	Herry ol	Teas	2		24a. Was a		utopsy findings available completion of cause of
<u> </u>	ate pag	Con	Atrial Gil	ori Mas	non			perform 1 Yes 2	ned? death? 2 No 1 ☐ Ye	s 2 No
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	pital:		Oth		ath (Check only on	θ)	Assisted
of Vital Records,	Phys this ral dii	- To	1 Yes 2 No	28a. Date of Injury	ER/Outpatie 28b. Time o		4 Nutsing	Home 5 Reside	ence 6 X Other (Spe ow injury occurred	Living
OU	Attending Ph r death. ector: After th by the funeral	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year	njury	Wor	k? Yes 2 □No			
Division	or Attendi after death. Director: A in by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury . A		reet, factory, office		28f. Location (St City or Town	reet and Number or F	iural Route Number,
ā	s afte	Certification:	4 Homiciae	building, etc. (Spe	эспу)			City of Town	i, State)	
	To the Hospital or Atti within 24 hours after de To the Funeral Directi completely filled in by t	dical	(Check only 2 Medical Examine	ian: To the best of my l	knowledge, dea ination and/or in	th occurred at the tin	ne, date and place pinion, death occ	ce, and due to the ca curred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	thin 2 the of the implet	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	2	9d. Date signed (Mon	th, Day, Year)
	or with con		1 .00-	Com	8	T 11	8101		Model	2 2007
			30. Name and address of person who com	pleted cause of death (tem 23a) (Tvpe	, Print)		^	1 0	
	10+1		30. Name and address of person who com Don na Cham b 31. Date filed (Month, Day, Year) APR 1 6 200	ers MD 13	33 Del	iense Hu	vy Suite	112 Ani	napolis M	D 2140
	Sta		31. Date filed (Month, Day, Year)	32. Rasistrar's Si	gnature	1	•			
	Regist	rar	HAK T D SAI	MANUE	J. J.	and the				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. (... 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 200) O HITCH April 11 James /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Worth west Heria mel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**X**M 2□ F Days Hours Yrs. 05-12-1933 Director Maryland 214-30-8938 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d, Inside City Limits 10a. State 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 Yes 2 No Director Maryland Somerset Princess anne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2845 Venton Road 21853 USA Funeral 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: ρ 3 ☐ Widowed 4 ☐ Divorced Black Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) other traumatic event, the Trucking Co. Truck Driver 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fili ment of Health and Mental H ant: If Item 27 is marked ott ဥ James Thomas Hitch, Sr. Maggie Doane 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health ar Important: If Item 27 is any injury or other trau 2845 Venton Road, Princess anne, Maryland 21853 Shelly Hitch / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
John Wesley U.M.
Church Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04-17-2007 | Westover, Maryland 22 Name and Address of Facility
Bennie Smith Funeral Home
917 W. Isabella Street, Salisbury, Maryland 21801 21. Signature of Funeral Service Licensee 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, si of control of the cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARA to tenel. /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause in the discussion of the cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed burial-trar esa inche Due to (or as a consequence of): physician ASILMS the IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant for 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2₽Ño Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

2+3

or Vital Records, P.O.

Baltimore, Maryland 21215-0036

State Registrar

APR 1 6 2007 DHMH 17 Rev 1/2001

Medical

29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

J -

de

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5701

egistrar's Signature

Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Cours

029085

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, Day **Physician** April 14, 2007 11:27 A M Robert Eugene Joyce /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9 Chestnut Street, #218 Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ★ M 2 □ F Months Days Hours Min. Director 507-34-6812 73 5, 1933 Nebraska Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits 10b. County show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Maryland Montgomery Gaithersburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 9 Chestnut Street, #218 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify. 3 Widowed 4 Divorced Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hyglene. int: If Item 27 Is marked other than "natural", ury or other traumatic event, the Medical Exa Year or Dates White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Teacher's Aide 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Michael Joyce Florence Leininger 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13401 North Rancho Vistoso, #213 Oro Valley, Arizona 85755 19a. Informant's Name/Relationship (Type. Print) George W. Joyce (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o April 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Calvary Cemetery 2007 Sutton Nebraska 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licerses 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Part I. Enter the chean shock, or hand fiftur?
Immediat. Cay. (Pinal disease or antion o, of complications triat of List only one cause on ea the death. So not enter the mode of dying, such as cardiac or respiratory arrest, Physician Arrythmia resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner ig physician and as the burial-transit death certificate be executed Hyperlipidemia Due to (or as a consequence of) Physician/Medical been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) I Yes 2 No 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Sleep Apnea 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has the irector, page 2 s autopsy performe death? 2□ No 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 X Yes 2 □ No ပို 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) Injury 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

P.O. Box 68760, Division or Vital Records,

> State Registrar

cal

(Check only

J⁄ohn/

29b. Signature and title of certifier

S.

31. Date filed (Month, Day, Year)

APR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Pagistrar's Signature

Saia, M.D.,

18

29c. License number

1201 Seven Locks Road, #202, Rockville, MD 20854

D10493

29d. Date signed (Month, Day, Year)

April 16, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Enid O. James April 15, рм 2007 1:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Days Hours 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 □ M 2 😿 F Director 073-50-5272 11, 1925 Antigua, West Indies Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland it and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes ⊋☐No Funeral Director Maryland | Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 1135 University Blvd., West, 20902 <u>Antigua</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 Ill If Yes, Give Year or Dates: 2 NO Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse's Aide 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edwin Carter P Althea Soanes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sment of Health an ant: If Item 27 Is uny or other traun Keithroy James/ Son 4 Bryant Crescent, Apt. 2G, White Plains, NY 10605 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 27, April Pinelawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Farmingdale, New York 2007 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Acute Hepatic Necrosis
Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Septic Shock le to (or as a consequence of): Examine executed burial-transi and Pneumonia Due to (or as a consequence of): P.O. Box 68760 attending physician The law requires that the death certificate be Physician/Medical Terminal Cor Pulmonale use as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 🗆 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signed page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Acute Renal Failure, Diastolic Dysfunction, 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Type II Diabetes Mellitus autopsy performed? certificate 2 ₩ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p

State Registrar

DHMH 17 Rev 1/2001

Medical

4 Homicide

(Check only one)

29b. Signature and tipe of certifier

30. Name and address of person

31. Date filed (Month, Day, Year)

APR

18

29a. Certifier

Zuniga, M.D 1500 Forest Glen Road, Silver Spring, MD 20910

who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D47867

29d. Date signed (Month, Dav. Year)

April 15, 2007

Division or Vital Records, P.O. Box 68760.

		Please				Indelible Ink					9	
		For 1 _ State	State of Ma	ırylan		epartment of F			lental Hy	giene	9	
	N.ET	Registrar Decedent's Name (First, Middle, Las	nt)		(Certificate of	Deat	n	2. Date of Do	Reg. No	2007	3. Time of Death
Physicia /Medic	_	BENJAMIN FRANKLIN							Month MARCH	30	y Year 2007	16:20 PM
Examin	143	4a. Facility Name (If not institution, give				4b. City, Town, o	r Locatio				. County of Deal	
	χ	UNION HOSPITAL 5. Social Security Number 6. S	ex 7. Age	e (In yrs. I	last birth	ELKTON day) If Under 1 Year	If Und	ler 24 Hrs.	8. Date of Bi	rth	ECJ.L 9. Birt	hplace (State or Foreign
Funeral Director			X M 2□F	50		S. Months Days	Hour		(Month, D	ay, Year	957 MAR	untry)
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sath w		315 KIDWELL AVENUE	12. Was Decedent 8	Ever in II	9	21617	lienanic	Origin? (Spe	orify Vee or N		TED STAT	
urs after death v ral", or items 23e Examiner must	Funeral	11. Marital Status1 X Never Married 2 Married	Armed Forces? 1 □ Yes 2 1 1 1	lo	J.	 Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ▼ No 			Rican, etc.)		Black, Whit	e, etc.
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should be filed within ond Mental Hygiene. marked other than imatic event, the M	ို	BENJAMIN FRANKLIN 19a. Informant's Name/Relationship			19b. I	Mailing Address (Street			ABETH I al Route Numi			Zip Code)
and 2 satth ar 27 is er trau		HARRIET SMITH/SIST	•			71 SADDLEBA						
of He		20a. Method of Disposition 1	Removal from State	20b. P	lace of [emetery	Disposition (Name of crematory or other pla	ce)		IL 4,	20c. L	ocation - City or	Town, State
t. Pag rtment rtant: njury		4 ☐ Donation 5 ☐ Other (Specifical Signature of Funeral Service Licentage)	/)	STE	VENS	VILLE CEME						E, MARYLAND
permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.		21. Signature of Fulleral Service Licer				FELLOWS, H 106 SHAMRO						L HOME, P.A.
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eath certificate be executed attending physician and for use as the burial-transit	Physician/Medica		d									
tth cert tendin rr use	an/IM	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth			3 □Ectopic pregnanc	у				23d. Date of del	ivery Day Year
he dea the at thed fo	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of d	eath	5 ☐ Other (specify) _	-				WOITH	Day Year
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law re las be	Completed	Schilo phro	414						24a. Was	psy	prior to	utopsy findings available completion of cause of
The ficate h									1□ Yes	ormed? 271N	death? 0 1 ☐ Yes	2 No
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after of Direct of In by	Certification:	4 ☐ Homicide determined	building, etc	. (Specify	y)	n, street, factory, office		,	City or To	wn, Stai	ria Number of Ri 'e)	ural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier (Check only) 1 Certifying Ph	ysician: To the best on niner: On the basis of	of my kno examina	wledge,	death occurred at the ti	me, date	and place, death occur	and due to the	e cause(s) and manner as	s stated.
thin 24	Medical	one) 29b. Signature and title of certifier	and manner sta	ited.		29c. Licens					ate signed (Mont	
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(1/15)		30. Name and address of person who	completed cause of de	eath (Item	n 23a) (T	ype, Print)		,		l .	il.:	4.000
111/		Alfred A Pin 31. Date filed (Month, Day, Year)	10 MO U	M (D 4	H	or bital 10	0 13	200 5	treet	61	Ktou,	MO 21921
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07-03029 Dale Francis Jo

Med

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Physician xamine	"	Dale FRANCIS Jones	Month Da April 20, 2007	7 4c. County of D	
Admin		a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	h	Garrett	eatti
		2278 Michael Rd	o Data of Birth/A		. Birthplace (State or
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr Months Days Hours Min		F	oreign
Director	١	2/6-66-04/8 1×M 2 F 5/ Yrs. Wolding Bays	MAY 21, 1	1933	Country) MARY/ARREL
	H	Level Decidence of Decedent			10d. Inside City Limits
au k		Oa. State 10b. County 10c. City, Town of Eccation			1 Yes 2 X No
how de		Maryland GARRETT Long coning	1100	Citizen of What	Country?
urylam Sa-f s	읽	10f. Zip Code	l log.	45A.	
death with the Maryland or items 23a or 28a-f shu must be notified at once	Director	139 Fnost burg Road 139 Fnost burg Road 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Characterist Marieum Plant		·	American Indian, Black,
vith th	듄		to Rican, etc.)	White,	etc.
item ust b	Funeral	1 Never Married 2 Married 1 Yes 2 No		Specify:	white
fter d		3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: or Dates: 1 Yes 2 X No specify: or Dates: 1 16a. Decedent's Usual Occupation (Give kind of Dates): Decedent's Usual Occupation (Give kind of Dates): 16a. Dec	of work done	6b. Kind of Busi	ness/Industry
urs a	à P	15. Decedent's Education (Specify 6th) study that a during most of working life. DO NOT use it	etired)	Co	0.1
72 ho	ete	Elementary/Secondary (0-12) College (1-4 or 5+)			
5-0036 led within 72 hours after death with the Maryland ltygiene. other than "natural", or items 23a or 28a-f show any the Medical Examiner must be notified at once.	Completed	[2] 0 18.Mother's Na	ime (First, Middle, Ma	iden Surname)	
5-0 led w Hygie othe		17. Father's Name (First, Middle, Last)	el TRU	19	
AD 21215-0036 2 should be filed within 72 hours after h and Mental Hygiene. 27 is marked other than "natural", c martic event, the Medical Examings.	Be	Daniel Ellsworth Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Street and Number	or Rural Route Numb	er, City or Town	, State, Zip Code)
2 2 should nd M is m	2	1 1 - The state of the	2, LONAC	ening, 1	Maryland 2001
MD nd 2 sh alth an alth an rauma		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location -	City or Town, State
ages I and 2 should be fit of Health and Mental It. If item 27 is marked other traumatic event,		1 X Burial 2 Cremation 3 Removal from State	2007	Grants	Ville, Minyland
P P P P		20a. Method of Disposition 20a. Method of Disposition 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee 20b. Place of Disposition (Name of cemetery, crematory or other place) Crantsville Cemetery 22. Name and Address of Facility E.	chhorn-Me	Kenzie	Funoval Home Pit.
Balt permit, Departi Importinjury		21/Signature of Puneral Service Electrices	Lonneaning,	MARYIA	nd 21539
	_	21 Signature of Funeral Service Licensee Sensor Marin St. Amount	ac or respiratory arre	st, shock, or hea	Approximate Interval Between Onset and
vsician edical		Tailure. List only one cause of the lateral heigings			Death
∟xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			
		Sequentially list conditions, Due to (or as a consequence of):			
	Jer	Sequentially list continued, if any, leading to immediate cause. Enter Underlying Cause			
	miner	(Disease or injury that initiated (Disease or injury that initiated Due to (or as a consequence of):			
secuted and ransit	Ĭ	d.			
executed an and al - trans	eician/Modical	UNPENDED AMENDED			Carlinan
50, te be nysici	100	IF FEMALE: 23c. If yes, outcome of pregnancy	reanancy	23d. Date of Month	Day Year
Box 68760, seath certificate be the attending physic ed for use as the but	1 2	2 Fetal death 3 Ectopic pi past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pi	regriancy		
th cer	1 3	1 Yes 2 No 9 Unknown 9 Unknown			
BC ne dea	1	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part			inbute to the cause of death?
P.O.	3		1Ye		
S, F uires n sign	3		24a. Was auto		Were autopsy findings available prior to completion of cause of
w red	1		perfo	ormed?	death? 1 ✓ Yes 2 No
The la	aga	26.Place of Death (C			
an: 3	1,0	25. Was case released to the discussion	Nursing Home 5	Residence 6	✔ Other: Scene
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be exemple the physician of the configurate has been signed by the attending physician Affect this certificate has been signed by the attending physician Affect this certificate has been signed by the attending physician Affect this certificate has been signed by the attending physician and the part of the p	alli I	1 ✓ Yes 2 No Impatient 2 Endougates 28c Injury at Work?	28d. Describe	how injury occu	irred
of ng Pl	Inneral	27. Manner of Death 28a. Date of Injury Apr 17, 2007 1 Natural 5 Pending 1 Natural 5 Pending	mining acc	adent	
	oy the r	Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc	. 28f. Location	(Street and Nun	nber or Rural Route Number, City
Division tal or Attendi us after death.	I In D	Suicide 6 Could not be determined (Specify) Other (Coal Mine)	2278 Michae	el Rd, Barton,	
o D	rilled in	4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of the control of the contr	ce, and due to the ca	use(s) and manr	ner as stated.
ol 4 fu	completely	Certifying Physician: To the best of my knowledge, and the control of the control	curred at the time, dat		gned (Month, Day, Year)
To the I within 2	<u> </u>	and manner stated.			

Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified April 21, 2007

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

2007

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

Tasha Greenberg MD 31. Date filed (Month Day, Year) State

32. Registrar's Signature

Registra

mei	nded#5,	er	FH For TCHD, 04/23	/07, State of	Marylan	d / Depa <i>Cei</i>	artment rtificate	of H	ealth a Death	and Mer	ntal Hyg	giene Nog. No.	007	14166
			1. Decedent's Name (First, Middle	, Last)						2.	Date of Dea Month		Year	3. Time of Death
	Physici /Medic		ELEANOR L.	JAMES						AF	RIL	14	2007	10:35AM™
7	Examin		4a. Facility Name (If not institution	, give street and numb	ber)		4b. City, T			of Death			nty of Death	
			MEMORIAL HOSI						STON				TALBOT	
	Funeral Director		5. Social Security Number 213-24-0245 213-05-6294	6. Sex 7	. Age (In yrs. I	ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	Date of Birth (Month, Day R 11,	r, Year)	9. Birthpi Coun MARY	lace (State or Foreign try) TLAND
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation						1	0d. Inside City Limits
	Manyl 1 ehc	5	MD TAI	LBOT		EAS	TON							1 Yes 2 □ No
	death with the Maryland me 23a or 28a-1 ehow metal be mulffied at	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Coun	try?
	23s or	0	610 HOLLYDAY	24				2	1601				USA	
	after death with or Iteme 23s or infrer must be	era	11. Marital Status	12. Was Deced		S. 13.	Was Decede			igin? (Specify	Yes or No-	14. F	Race - Americ	
9			1 Never Married 2 Marr		No						an, etc.)		Black, White,	
5-0036		d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dat	es:		1 Yes 2	X NO	Specify:			Spe	cny: M	HITE
5-(15. Decedent's Caucation 15a. Decedent's Usual Occupation 15b. Coccife only highest grade completed) (Give kind of work done during most of working											16b. Kind of	Business/Inc	dustry
121	within ene. then	g .	Elementary/Secondary (0-12)	College (1-4	4or 5+)		DO NOT use					СНІ	LD CAR) F
121	filed with Hygiene other the		11 17. Father's Name (First, Middle,			DAI	CARE	IKU			irst Middle			<u> </u>
Maryland	s 1 and 2 should be filed withi F Health and Mental Hygiene. Item 27 Is marked other then other traumatic event, Land	william H. Bridges Leona S. Warner												
<u>lar</u>	2 sh and le m raum	1	19a. Informant's Name/Relations	-		1								Code)
	s 1 and if Health item 27 other tr	-	W. MICHAEL JAM	ES/SON	20h P	lace of Dispo		and the same	ST.,	EASTON	-			um Chata
Baltimore,	nit. Peges 'sariment of hoursent: If its injury or of		20a. Method of Disposition 1		late C	emetery, crei	matory or oti	her place		4/18/2			OCK, MA	ARYLAND
Balt	permit. Departr Importe any inju		21. Signature of Funeral Service	Oxforcesk	cf5/		ELLOWS	Addres HARI	s of Facilit	BEIN 8	NEWN	AM FUN	IERAL E	IOME PA
Physician Medical Examiner Sequentially list conditions, if any, reading to minerodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Publication Medical Examiner Physician Medical Examiner Physician Medical Examiner Physician Medical Examiner Physician Medical Examiner Sequentially list conditions, if any, reading to minerodiate cause. Enter Underlying Cause (Disease) or injury that initiated events resulting in death) Last Publication Medical Examiner Physician Medical										Month ontribute to the state of the state o	Day Year The cause of death? The cause of death?			
	To the H within 24 To the Fi complete	Medical	(Check only 2 Medical 29b. Signature and title of certifie	and manne	er stated.	uon and/or in		. License		un occurred a		29d. Date sig	ned (Month, I	Day, Year)
			· //	Malrow	This			1	725	957		41	17.07	
	+3		30. Name and address of person	WLCY MD	610	DUTO	Print) HMAN	v's	LANL	! E	ASTO	on, M	0 2	1601
	Sta Registr		31. Date filed (Month, Day, Year) APR 1	7 2007 32. Re	gistrar's Signa	ture	Luck	,						

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State	of Marylar		artment of rtificate of			lental Hy	giene Reg. No	6001	14167
			1. Decedent's Name (First, Midd	lle, Last)						2. Date of De Month	aath	Vone	3. Time of Death
	Physici /Medio		Eleanor A.	Komarins	ski					April	20,	2007 Year	5:55 A.M.
	Examin		4a. Facility Name (If not institution	on, give street and n	umber)		4b. City, Town,	or Location	of Death		40	. County of Death	1
			Beverly Health	Care			Hagers	stown			Wa	shington	n
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea Months Day	r If Under	24 Hrs. Min.	8. Date of Bi	rth	Q Right	
	Director		169-24-8600	1 ☐ M 2 🖾 F	8	39 Yrs.	Months Day	s Hours	Min.	June 6,	1917	0h	nplace (State or Foreign Intry) LO
1	2 .		Usual Residence of Decedent		1								
- 1	how the	_	10a. State 10b. County	Y		ty, Town or Lo							10d. Inside City Limits
Ė	B Wa	cto	MD Washii	ngton	На	igersto	wn						1 ☐ Yes 2 ☑ No
4	6 2 3	Director	10e. Street and Number				10f. Zip Code				10g. Ci	tizen of What Cou	untry?
4	23a	ai	16844 Petmar C	ircle			2174	+2			USA	A	
	90	Funeral	11. Marital Status	12. Was De Armed F	cedent Ever in U	l.S. 13.	Was Decedent of f Yes, specify Cu	Hispanic Or	igin? (Spe	ecify Yes or No Rican, etc.)	0-	14. Race - Amer Black, White	
2	or it		1 Never Married 2 Ma	If Yes G	2 XNo		1□Yes 2√N			. ,			hite
Ś	re in it	d by	3 XWidowed 4 ☐ Divorce	d Year or	Dates:		X.					opcony. W	
5	in the first	Completed		nt's Education est grade completed	()	(Give	dent's Usual Occ kind of work don	e during mos	st of worki	ing	16b. K	(ind of Business/l	ndustry
4	Para Para	ďμ	Elementary/Secondary (0-12)	College	(1-4or 5+)		DO NOT use retii	·ed)				l = 1-2	
٧ .	lygie tygie t, th	ပိ	12th	(=====		Seams	tress	40 14-4	ada Nia aa	- /FT A A A		lothing	
	d of	Be	17. Father's Name (First, Middle		_					e (First, Middle	, maider		
S :	should be filed within 72 hours atter death with the Maryland nd Mental Hygiene. marked other than "neturel", or Itema 23e or 28e-f ehow imarked other than "neturel", or Itema 23e or 28e-f ehow imatic event, the Medical Exerciner must be notified at	70	Steve	Hrivnal	K			Mar				Antolik	
~	N 42 = 9		19a. Informant's Name/Relation									or Town, State, Z	
5	end fealth m 27 har tr		Steve Kline /]	<u>Nephew</u>	20h (onens C		, VA 226	***************************************
5	rages nent of H int: # ite		20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal from	n State	cemetery, crei	sition (Name of natory or other p	3				ocation - City or 1	
	men tant:		4 ☐ Donation 5 ☐ Other (Specify)	Tw		y Cemetery		1			Lmont, P	
8	permit. Pages 1 en Department of Heal Important: If item 2 eny injury or other		21. Signature of Furneral Service	Licensee	0							h Funeral	Home
	40 = € a		107				05 N. Poto					.740	
	hysician /Medical		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a	each line.	nen	Λ.	cose	cardiac o	or respiratory a	irrest,		Approximate Interval Between Onset and Death 344045
E	Examiner				Corus a consec	quence or).							
	¢.	e	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a consec	quence of):						-	
3	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	S .									
5	exec n an	Еха	resulting in death) Last	Due to	o (or as a consec	quence of):							
	/sicie	dicai		d									
0	g phy as th	•											
5	andin use	Ician/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		Je					23d. Date of deliv	very
ם ו	d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	birth 2 ☐ Feta nant at time of o		Ectopic pregnan Other (specify)	cy				Month	Day Year
)	by th	Physi	9 □ Unknown	9□ Unk	nown								·
ָר אַ ר	To the Pospital or Attending Priystorent: The law requires may the dearn certificate be executed within 2 to the Funerel Director. After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	þ	Part II. Other significant condit	ions contributing to	death but not res	sulting in the u	nderlying cause g	iven in Part I	l.		tobacco Yes 2		the cause of death?
5	sho ohs	Completed								24a. Was	an	24b. Were aut	opsy findings available
ב ב	ne ia e ha:	Ĕ									ormed?	death?	opsy findings available ompletion of cause of
<u> </u>	ificet or, pa	ပိ	25. Was case referred to medical	al				00.81	- 10 - 11	1 Yes	2 D No	1 ☐ Yes	2 No
5	cert	00	examiner?	Hospital	Inpatient 2	158/0				(Check only		- 50:	
5 8	rithis rald	. To	27. Manner of Death			ER/Outpatier 28b. Time of	I JL DOA	41 <u>K</u> J NI				6 ☐Other (Spec	ify)
5	Afte fune	tlon:	1 Natural 5 ☐ Pendi	ing (Mo	e of Injury nth, Day Year)	Injury	W	ork? ⊒Yes 2 □		28d. Describe how injury occurred			
2	dead ctor y the	Certificati	3 ☐ Suicide 6 ☐ Could	I not be	e of Injury - At h	ome, farm, str				28f. Location (Street ar	nd Number or Rui	ral Route Number.
3	after Dire	erti	4 Homicide determ	build	ding, etc. (Special	(y)				City or To	wn, State	e)	
1	spire nours nerel fillec		29a. Certifier 1 Certifyi	ing Physician: To th	ne best of my kno	owledge, death	occurred at the	time, date ar	nd place a	and due to the	cause(s) and manner as	stated.
	24 r Fui etely	Medical	(Check only 2 Medica one)	I Examiner: On the	basis of examina nner stated.	ation and/or in	vestigation, in my	opinion, dea	ath occurr	ed at the time,	date an	d place, and due	to the cause(s)
	ompl	Me	29b. Signature and title of certification					se number			29d. Da	ite signed (Month	, Day, Year)
,	>-0		> Marien	of ma	4		D	283	365	-	1,	- 20-0	7
			30. Name and address of person	who completed car	se of death (Iter	n 23a) (Tyne	Print)				17-		
151	4-10		MAW 2 AR.	D. SHI	- 0 -	$8^{n 23a}$	ull 81	Veil-	110	quest	mu	- 20-0 MD 2	Duo
	Sta	te	31. Date filed (Month, Day, Year	r) 32.	Registrar's Signa				1,0	U			
	Registr		APR 2	0 2007	6	A. 1	12						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O O TO

			1 - For State Registrar	State of Ma	ceCe	artment of He ertificate of L		nental Hygie Reg.	6001	14168
ľ	Physici /Medio		1. Decedent's Name <i>(First, Middle, La</i> Emil	st) Euge	ne	Kohler		2 Date of Death April 16,	Bayo7 Year	3. Time of Death 3:29 A M
2	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County ol Death	
		Ft. Washington Hospital					ington		Prince Ge	
	Funeral Director		370-40-3932	ex 7. Age	77 Yrs.	II Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Dec. 26, 19	9. Birthp Court 129 Wash	lace (State or Foreign try) ington, DC
	anyland •how	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge	1	0d. Inside City Limits 1 ☐ Yes 200 No					
	with the N sa or 28a-1	Funeral Director	10e. Street and Number 705 Kelly Road		Ft. Washin	10f. Zip Code 2074	44	10g.	Citizen of What Country?	
920	be filed within 72 hours atter death with the Maryland tal Hygiene. d other than "natural", or iteme 23s or 28s-1 show event, if a Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	ver in U.S. 13. 13. 1951~ 1954	Was Decedent of His If Yes, specify Cubar		ecify Yes or No- Rican, etc.)			
Maryland 21215-0036	vithin 72 ho one. Ihan "natu a Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5	(Give	o kind of work done during most of working			b. Kind of Business/Industry Federal Government	
N	filed y Hygie other t	ပိ	17. Father's Name (First, Middle, Last)	<u> </u>				e (First, Middle, Maid	den Sumama)	
ylan	Men	To Be	Fmil Bruno Kohler Wilhelmina						Kunst	
	d 2 st th ar 7 is trau		19a. Informani's Name/Relationship (Eblin Kohler / Wife	Type, Print)		ing Address (Street at Kelly Road Ft			ty or Town, State, Zip 1 20744	Code)
Baltimore,	Pages nent of ant: if it		20a. Method of Disposition 1 ☐ Burial 2 ⚠ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place of Disponentery, cre	osition (Name of matory or other place Crematory	,)	Date 200	Location City or To gewater, Mar	
Ball	permit. Departr Imports any Injo		21. Signature of Funeral Service Letcen	wann		Road Oxon Hill, Maryland 20745				
	Physician /Medical Examiner		23a. Part1. Enter the disease or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions			Approximate Interval Between Onset and Death				
68/60,	w requires that the death certificate be executed been signed by the ettending physicien and should be detached for use as the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):		1			
.C. BOX t	the death certify the ettending iched for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date ol delivery Month Day Year	
as, r	requires that the een signed by th nould be detache	ρ	Part II. Other significant conditions of HYPEXTENSION		n in Part I.	23e. Did tobacc	co use contribute to th	e cause of death?		
Kecords,	siclen: The law rec certilicate hes bee lirector, page 2 shou	Completed	PERIPHERAL	24a. Was an autopsy performed	prior to completion of cause of					
VII	ifficat or, pa	ပို	ARRYTHMIAS 25. Was case referred to medical	(CARD	THE)		00 Place of Death	1 ☐ Yes 2 D	No 1 ☐ Yes	212 No
>	ysiclan: is certilic director,	0	examiner?	Hospital: 1 ☐ Inpatien	t 2 P/Outpatier	0.4	lal -	n (Check only one)	6 ☐Other (Specify	
lon or	ath. r: Atter thi	ation: T	27. Manner of Death 1 SNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Time o	f 28c. Injury		28d. Describe how in		<u>'</u>
DIVISION	s etter de s etter de et Directo ed in by th	Certification	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ry - At home, farm, sti (Specify)	reet, lactory, office	Route Number,			
	To the Hospitel or Attending Physicien: within 24 hours efter death. To the Funeral Director: After this certifica completely tilled in by the funeral director,	Medical (29a. Certifier (Check only one)	ysician: To the best of iner: On the basis of and manner stat	examination and/or in	h occurred at the time vestigation, in my opi	e, date and place, a nion, death occurre	and due to the cause ed at the time, date a	e(s) and manner as sta and place, and due to	ited. the cause(s)
	Tot withi Tot	₹	29b. Signature and title of certifier	PHYS	ICIAN	29c. License		A	Date signed (Month, E	1.0
1	20/		30. Name and address of perso who co		ath (Item 23a) (Type,	Print)	on Ro	AD SUT	PRIL 16	PORT
2	Sta Registra		31. Date filed (Month, Day, Year) APR 1 8 2007		's Signatur	,			/	WASHINGT

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	1- State of Maryland / Dep	artment of Health and I	Mental Hygiene	7 11.169							
Physician	1. Decedent's Name (First, Middle, Last) Phyllis H. Krabill		2. Date of Death Month Pay Year 4/14/2007	3. Time of Death 10:30pMn							
/Medical Examiner	4a. Facility Name (If not institution, give street and number) Spa Creek Center	4b. City, Town, or Location of Death		ath							
Funeral Director	5. Social Security Number 6. Sex 1 M 2 This F 7. Age (In yrs. last birthday, 78 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Bir C	thplace (State or Foreign ountry) DE							
e Maryland Ba-f show tiffed at	Usual Residence of Decedent			10d. Inside City Limits 1 ☐ Yes 2 📉 No							
th with the Mar 23a or 28a-f st 1st be notified	10e. Street and Number 1554 Bandury Ct.	10f. Zip Code 21114	10g. Citizen of What C	ountry?							
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed ★★Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes ※ No Specify:	pecify Yes or No- o Rican, etc.) 14. Race - Am Black, Whi Specify: Wh	te, etc.							
ed within 72 houygiene. Net than "naturat, the M-dical E. Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1 Ta	dent's Usual Occupation kind of work done during most of wor DO NOT use retired) X Auditor	MD Governm	·							
ould be filk narked oth natic even	17. Father's Name (First, Middle, Last) Karl Harrison	Mary Gri									
les 1 and 2 sh of Health and of tem 27 is in or other traum	Linda Parker Daughter 1554 20a. Method of Disposition 20b. Place of Dispo	Bandury CT. Croft	on, MD 21114 Date 20c. Location - City or								
permit. Pag Department Important: any Injury o once,	4 □ Donation 5 □ Other (Specify) Metro Cre 21. Signature of Fungfal Service Licensee 2	2. Name and Address of Facility Ha	/2007 Baltimore, rdesty Funeral Hom								
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ifficate be executed g physician and as the burial-transit edical Examir	resulting in death) Last Due to (or as a consequence of): d.										
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w requires that the d been signed by the should be detached leted by Physic	Part II. Other significant conditions contributing to death but not resulting in the u		cco use contribute to the cause of death?								
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hystciar this certif al director	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatient	Othor	th <i>(Check only one)</i> ome 5 ☐ Residence 6 ☐Other <i>(Spe</i>	ecify)							
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I Medical Certification: To Be C	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred								
oital or At urs after d oral Direct illed in by	4 Homicide determined building, etc. (Specify)		28f. Location (Street and Number or R City or Town, State)								
the Hospi hin 24 hour the Funer apletely fill	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occu	rred at the time, date and place, and du	e to the cause(s)							
To t To t Com	29b. Signature and title of certifier	D57028	29d. Date signed (Mon								
5	30. Name and address of person who completed cause of death (Item 23a) (Type, Adt TVA Chopta, M.D. 600 Ridge)	Printe . #231 Ar	inapolis, MD 2	2401							
State Registrar	31. Date filed (Month, Day, Year) APR 1 7 2007 32. Redistrar's Signature	Locale	,								

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Apri Gail Lenore LUTZ 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 29, 1936 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 □ XI 70 Yrs. 217-32-6604 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Maryland | Washington Funkstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral P.O. Box 795 21734 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: þ Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Driver Buses permit. Pages 1 and 2 should be filled. Department of Health and Mental Humbortant: If Item 27 Is most any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Frank Thomas Lutz Gertrude A. Brady 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Michael Henry - Nephew</u> P.O. Box 921 Funkstown, Maryland 21734 acc of Disposition (Name of Date 20c. Location - Cit 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 4/18/07 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metaslatic 4100 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To nours after death.

neral Director; After this y filled in by the funeral di After this 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

APR 19 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ir Guedenet 21 Wyand Drive 32. Registrar's Signature

and manner stated.

29c. License number

p32518 April 17, 2007 Heedysville Maryland 21756

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Albertine Thomas Lancaster /Medical April 24, 2007 6:00 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospital St. Mary's Leonardtown If Under 24 Hrs. Hours Min. if Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🛛 F Yrs. Director 075-18-7317 82 07/16/1924 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2X No Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 44032 Flagstone Way 20619 United States by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced **Black** Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Elementary/Secondary (0-12) College (1-4or 5+) Social Services 6 Clinical Social Worker other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfred Thomas Agatha Estridge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44032 Flagstone Way, California, Maryland 20619 John G. Lancaster/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of I
Important: If its
any injury or o
once, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Raymond New Cem. 05/01/2007 | Bronx, New York 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Inheral Service Licens Fr. M00052 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY **Physician** /Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE PULLINARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the burial-tran Due to (or as a consequence of) Physician/Medical as asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Attending Physician: after death

filed within 72 hours after death with the Maryland

"natural",

al Hygiene.

is marked o Pages 1 and 2 should be nent of Health and Mental

item 27 i

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attending physician

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has

Baltimore, Maryland 21215-0036

State Registrar

Funeral

To the within 2

cal

29b. Signature and title of certifier

29a. Certifier

MD

29c. License number D 56096

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

4-14-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASSOCIATES HOLLIWOOD MD AJBINDER GILL SHAH

and manner stated.

31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 6 2007

			For State (artment of Health and ertificate of Death	Mental Hygier	2007 16172																
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year																
	/Medic	cal	Mary Geraldine Miller			April 2	24 2007 20:16 P ^M																
X	Examir	er	4a. Facility Name (If not institution, give street and not Harford Memorial Hospit		4b. City, Town, or Location of Dea Havre de Grac		4c. County of Death Harford																
	Funeral		Social Security Number	7. Age (In yrs. last birthday		s. 8. Date of Birth	Birthplace (State or Foreign																
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	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits																
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	or 28	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?																
	ath w	rall	1973 Trappe Church Rd		21034		S.A																
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or itema 23a or 28a-1 ehow other than "natural", or itema 23a or 28a-1 ehow event, the Medical Examinar must be notified at	by Funeral	Armed F	2 No ive	Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☐ No Specify:	Specify Yes of No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White																
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nor	S = = 0		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State cemetery, cre	matory or other place)	200.																	
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Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	3 Surcide 6 Could not be determined 28e. Plac bullo	e of Injury - At home, farm, st ling, etc. <i>(Specify)</i>	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)																
	To the Hospi within 24 hou To the Funer completely fill	Medical	one) 2 Medical Exeminar: On the tand mar	e best of my knowledge, deal pasis of examination and/or in nner stated.	th occurred at the time, date and place avestigation, in my opinion, death occ	urred at the time, date a	and place, and due to the cause(s)																
	with To Con	2	29b. Signature and title of certifier	200 D	29c. License number	29d. 1	Date signed (Month, Dey, Year)																
	, t		20 Name and address of passes who completed	sa of death (from 2021) T	Da' DC	1 09	100101																
	J4 Sta	10	805 South Uni	se of death (Item 23a) (Type, On HUCOU Registrar's Signature	e Havre de	2 Grace	8016 DM.																
	Registr		MAY 0 9 2007	H Aran	وميع	_																	

DHMH 17 Rev 1/2001

Miller, Mary Geraldine

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death , Day 2007 Year April 23, **Physician** Richard D. McKenzie 21:22 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death WMHA Braddock Campus Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 1 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1**x**□M 2□ F Maryland 219-44-0130 Yrs Director 61 10,1945 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or itams 23a or 28a-f show It a Medical Examinar must be notified at Director 1 ☐ Yes 2 No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14304 Niners Lane 21502 USA death 12. Was Decedent Ever in U.S. Armed Forces? 12/65 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ita any injury or other traumatic event, IL a Modical Examina. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No Specify: White δ Specify: 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Shipping Clerk Food Production 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Marshall McKenzie Emma (Wertz) McKenzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle R. Harris Daughter 606 Louisiana Ave., Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Dollation 5 □ Other (Specify) Sunset Memorial Park Apr 27 07 Cumberland, MD 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Hypertensive Cardiovacca. 22. Name and Address of Facility Hafer Funeral Service, PA 1302 National Hwy., LaVale, MD Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as the attending 980 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ţ in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 99 The law requires 4 Unknown page 2 should Completed 2 🗌 No 3 Probably Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performen? Yes 20 No 1 Yes or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled the Hospital 29a. Certifie Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) 209151 24, 200 Not 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Snow, MD 124 3rd Street W., Cumberland, MD 31. Date filed (Month, Day, Year) State Registra 0 2 2007

DHMH 17 Rev 1/2001

23. Part I. Stort for displayable for the control of the country o				1 - For State Registrar		State of	Maryland		artment of trificate of		d Mental Hy	giene Reg. No.	007	14174
Donald Louis Mergler Framed Director F	1	Dhygiei	20	Decedent's Name (First,	Middle, La	st)							Year	3. Time of Death
The contract of the contract o											April			9:15A M
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** М 04 26 07 1812 Morris Ruth /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Allegany** WMHS Braddock Campus Cumberland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jul 17, 1919 7. Age (In yrs. last birthday, 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Country) Months Min Hours 1 □ M 2 □ F Jul 17, Director 214-52-2188 death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notifiled at Y□Yes 2□No Cumberland MD Allegany Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 JFK Apts. Mechanic Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: 2 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home <u>Homemaker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental I Ethel Rebecca (Davis) Wagoner William Michael Wagoner 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If Item 27 Is or other tra 250 Stoneymeade Drive Winchester Steven Morris son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/30/2007 St. Mary's Cemetery Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensi 108 Virginia Avenue: Cumberland, MD 21502 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, prock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cute My O Caroli. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No page 2 s autopsy performed' 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO 2 1 Tyes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Matural 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis/of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner/stated. (Check only

Division or Vital Records. P.O. Box 68760. within 24 hours after deau...

To the Funeral Director:

State

one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. VIKRAMAD HIA ROORA; 921 S

Registrar DHMH 17 Rev 1/2001

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924 Seton DRive Comberland, ND

		1 - For State Registrar	State of Maryland	•	artment of H			giene	7 14176	
Physici: /Medic		Decedent's Name (First, Middle, Last) Jorge	Roberto	M	orales		2. Date of Dea Month April	ath Day Yea	3. Time of Death 3:10a _M	
Examin		4a. Facility Name (If not institution, give st. Doctor's Commu 5. Social Security Number 6. Sex			4b. City, Town, or Lanha	m	th	4c. County of De Prince	George's	
Funeral Director			M 2□ F 56	Yrs.	Months Days	Hours Min	(Month Day	y, Year)	Country) Peru	
he Maryland 8a-f ehow	Director			reent	elt				10d. Inside City Limits 1 🖫Yes 2 🗆 No	
ath with t 23a or 2 ust be n	ral Dir	10e. Street and Number 6156 Springfie	eld Ter. #3	01	10f. Zip Code 20770			10g. Citizen of What Peru	Country?	
72 hours effer death with the Maryland natural; or teme 23s or 28s-1 show dical Examiner must be notified	by Funeral	11. Marital Status 1 Never Married 2 Narried 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 ፟፟ Yes 2 ☐ No			14. Race - Au Black, W Specify:	merican Indian, hite, etc. White	
- 4	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)		(Give life. L	dent's Usual Occupi kind of work done of DO NOT use retired	during most of wo 1)	orking	16b. Kind of Busines		
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es 1 end of Heelth fitem 27 r other tr		19a. Informant's Name/Relationship (Typ Jorge Luis Mora 20a. Method of Disposition 1 ♀Burial 2 □ Cremation 3 □Re	les/Son	6156 ace of Dispo		field '		20c. Location - City	elt,Md20770	
permit. Pag Depertment importent: i any injury o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ucensee	2 -	22 F	HILIP D	rinal	DI FUNE	RAL SERV	ICE, P.A.	
Physician /Medical Examiner	Ical Examiner	23a. Part 1. Enter the lisease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) 3. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. d.	Due to (or as a consequence to (or as a consequence)	ect; ence of):			c or respiratory ar		Art roximate Interval Between Onset and Death	
auth certific ettending pl	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown							delivery Day Year	
w requires thet the de been signed by the should be detached	Ď	Z36. Did toback							cco use contribute to the cause of death?	
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ath. or: After the funeral							28d. Describe how injury occurred			
withing 4 hospital or Attending Physician: The withing 4 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Stree City or Town, S							Rural Route Number,	
ne Hosp 124 hou ne Fune pletely fi	Medical	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examine	cian: To the best of my know er: On the basis of examinat and manner stated.	wledge, death ion and/or in	n occurred at the tin vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the ourred at the time, or	cause(s) and manner date and place, and c	as stated. fue to the cause(s)	
	×	29b. Signature and title of certifier	1 120	to 0	29c. Licenso		_	29d. Date signed (Mo	onth, Day, Year)	
3		30. Name and address of person who con	nplet se of death (Item	23a) (Type,	Print)	ת בנים חה : מנד	cher	- I	1. 1	
Sta Registr		31. Date filed (Month, Day, Year) APR 18 200	32 Registrar's Signat	ture	entis	1700		78/	land and	

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 9:37 p M George Nicholaos Michas April 13, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 809 Gregorio Drive Silver Spring Montgomery Birthplace (State or Foreign Country) If Under 1 Year If Under Months Days Hours Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months 1 X M 2 🗆 F 85 June 21, 1921 Director 177-24-2654 Greece Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County at 1 Yes 2 No Examiner must be notified Directo Silver Spring Maryland | Montgomery 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 0 items 23a 809 Gregorio Drive 20901 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant of Health and Is marked other than "natural", or items 23 ant; If item 27 is marked other than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Waiter Restaurant Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nicholaos Michas Foukaini Kazavouli 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Michas - Spouse 809 Gregorio Drive, Silver Spring, Maryland 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State Department of H Important; If ite any Injury or ot 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Gate of Heaven Cemetery 4/17/2007 Silver Spring, Maryland 21. Signature of Funeral Ser ic Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and have the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the disease, or complications that caused the death. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Colon Cancer 5½ years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lucaus of Juny that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Dav Year 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division or Vital Records. Completed by 1 Tes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed certificate 1 Yes 2 No Hospital or Attending Physician; ector, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖺 Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? After Injury (Month, Day Year) 1 Natural 5 Pending To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) LONGE D43083 April 16, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Sotos, M.D., 9707 Medical Center Drive, Suite 300, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State APR 18 2007 Registrar

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30. Name and address of person who comp

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eted cause of death (Item 23a) (Type, Print) , WASHING 70N COON 74

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 15 Pay 2009 **Physician** Joseph Leroy Moore /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hagerstown 36 Broadway If Under 1 Year | If Under 24 Hrs. 6. Sex 1 → M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 90 Yrs. Director Nov 8 1916 Maryland <u>215-26-7770</u> Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f show item 27 ie marked other then "naturel", or items 23a or 28a-1 ebov other traumatic event, the Modical Examinar must be notified at 1X Yes 2 □ No Hagerstown Washington Director Maryland Pages 1 and 2 should be filed within 72 hours after death with the inent of Health and Mental Hygiene. snt: If Item 27 Ie marked other then "naturel", or Items 23a or 28a: 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21740 36 Broadway Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: white 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) City Government Superintendent 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lilly Dail Moore Hubert M. Moore 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 633 Treys Drive Winchester Virginia Gerald L. Smith Jr. Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ŏ St. Paul's Cemetery 4-18-2007 Clear Spring Maryland permit. Page Department of Important: If eny Injury or once. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown Maryland 21742 Ling Junes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death the Pancreas Immediate Cause (Final **Physician** of Concer the me year disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown sate hes been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ MG 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed

The law requires that the death certificate be executed Records. Division of Vital Hospital or Attending Physicien: within 24 hours efter death To the Funeral Director: completely filled in by the Be Completed 200 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Besidence 6 Other (Specify) 1 □ Yes, 2 □ 16 Medical Certification; To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Contifying Physician: To the best of my knowledge ideath conumed at the time, data and place, and due to the reuse(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

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State Registrar 31. Date filed (Month, Day, Year)

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death.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 14, Day 2007 Roberto Mendez Jose 3:11 ₽ M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Months Hours X M 2□F Yrs 212-17-9270 57 April 8, 1950 El Salvador, C.A Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9202 Piney Branch Road #203 20903 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married 1 XYes 2 □ No Specify: Specify: 3 Widowed 4 Divorced Salvadorian Year or Dates: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fernando Loza Ernestina Mendez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberto Mendez 9202 Piney Branch Road #203, Silver Spring MD 20903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 4/18/2007 Silver Spring, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham MD 20706 23a. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final terioscierotic carchiovasculaschisen 1-car disease or condition resulting in death) Due to (or as a consequence of): bertension Caquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 ☐ Yes 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Manner of Death 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

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death with the Maryland

Pages 1 and 2 should be filed within 72 hours after ann of Health and Mental Hygiene.

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altimore,

Records, P.O. Box 68760.

or Vital Physician:

Division Hospital or Attending

29c. License number

55410

29d. Date signed (Month, Day, Year)

04/14/2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Day Month **Physician** 25, 2007 6:20 p^M Pear1 Maxson April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Solomons Nursing Center Calvert Solomons Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🗓 F Director 537-12-9346 08/08/1922 Oregon Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director California Maryland | St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22581 Torino Drive Completed by Funeral 20619 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 🛣 No Specify 3 Widowed 4 □ Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Saltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Charles Coombs <u>Frances Pearl Swan</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathie D. Lamoureux/Daughter 22581 Torino Drive, California, MD 20619

pe of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen-Washelli Memorial Park 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department or Important: If any injury or 4 □ Donation 5 □ Other (Specify) 04/30/2007 | Seattle, Washington 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of) Examiner SEVERE MITR Due to (or as a consequence of) MITRAL REGURGITATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed VALVULAR DISEASE burial-tran Due to (or as a consequence of) P.O. Box 68760, the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performe or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 12 Natural 2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M 3wte 310 Prince Frederick 31. Date filed (Month, Day, 32 F State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Gerald Philip Marski April 24, 2007 /Medical 9:45 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Solomons Nursing Center Calvert Solomons If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs 1X M 2□ F Hours Director 114-03-6742 06/14/1915 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director Maryland St. Mary's Leonardtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examinations. Funeral 20488 Deer Wood Park Drive 20650 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 ☐ Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Engineer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Albert Marski Catherine McDonough 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane Walsh/ Daughter 20488 Deer Wood Park Drive, Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cr. 04/27/2007 Charlotte Hall, MD 21. Signature of Eneral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A.

42. Ward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac /Medical Due to (or as a consequence of): **Examiner** Caroliovosular Disease Atherosclembic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Heart 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Dementia 24a. Was an autopsy performed? /es 2 No Diahetes mellitus 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 1 Inpatient 2 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) after death.

I Director: After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D. 50653 4-25-2007 as

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State Registrar 31. Date filed (Month, Day, Year)

Deale v. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Pegistrar's Signature

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		For State	State of Maryla			t of Healt e of Dea			iene. U	U /	14183
	WK.	Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Dea		Year	3. Time of Death
Physic		ALTHEA VIRGINIA						APRIL		007	5:50 P M
/Med Exam		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or Local	tion of Death		4c. Coun	ry of Death	
ZXum		TALBOT HOSPICE H	OUSE			EASTON				ALBOT	
Funera	1	5. Social Security Number 6. Se		s. last birthday)	If Under Months	1 Year If U	urs Min.	8. Date of Birth (Month, Day	, Year)	Cour	
Directo	r	218-12-2905	84 84	Yrs.				JAN. 7,	1923	MARY	LAND
pur *		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	ocation					1	0d. Inside City Limits
Aaryla F sho	ঠ	MD TALBOT		EASTON							1 ☐ Yes 2X No
ith the Marylan or 28a-f show	Director	10e. Street and Number			10f. Zip	Code	***		log. Citizen o	What Cour	ntry?
3a or	٥	5 PARK LANE				2160	l		U	SA	
death with the Maryland ma 23a or 28a-f show r must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Dece	dent of Hispani offy Cuban, Me	c Origin? (Sp xican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ace - Americack, White,	
or He c		1 Never Married 2 Married	1 □Yes 2 X No If Yes, Give		1 ☐ Yes		ecity:		Spec	ify:	T 1992
Y I.Z. 13-0000 Jainin 72 hours after death with the Maryla jiene. I than "natural", or lieme 23a or 28a-f shov The Mudical Examinar must be notitied at	d by	3 X Widowed 4 □ Divorced	Year or Dates:	16a Dasa	dont's Hou	al Occupation			16b. Kind of		dustry
n 72 t	Completed	15. Decedent's Edi (Specify only highest grad	de completed)	(Give	kind of wo	rk done during	most of worl	king	,		
within 72 and the main of the Medic	d m	Elementary/Secondary (0-12)	College (1-4or 5+) -0-	ACCO	UNTIN	G CLERI	K	•	ESTING	HOUSE	
9 2 3 2	a)	17. Father's Name (First, Middle, Last)	-	<u> </u>		18. 1	Mother's Nam	e (First, Middle,	Maiden Suma	ame)	
9 70 ->	0	JAMES CLARK WOOL	WARD				MARY	LEONA M	IARVEL		
OTC, MATYIAIIU es 1 and 2 should be fili of Health and Mental Hi litem 27 is marked oth		19a. Informant's Name/Relationship (7						ral Route Numbe			
C 2 '44 E		DONALD McCLYMENT			2000		ROAD,	QUEENS'I	20c. Location		
attimore, rr it Pages 1 a parment of Hea partent: if Item		20a. Method of Disposition 1 TBurial 2 Cremation 3		. Place of Dispo cemetery, cre	matory or	other place)	i m			-	
Pages ment of ent: If It		*4 □Donation 5 □Other (Specify	CH	ESTERFI				-2007	CENI	KEVIL	LE, MD
permit Page Department of Importent: If Any injury or	i DC	21. Signature of Funer Pervice Licen	tole w	FF	T.I.OWS	nd Address of I	NBEIN	& NEWNAM	FUNER	AL HO	ME, P.A.
4024	4	23a. Part1. Enter the discase, or com	lications that caused the de	ath. Do not en	18_S	LIBERT de of dying, su	Y ST., ch as cardiac	CENTREY or respiratory ar	rest,	MU ZI	Approximate
		shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.	1001							Interval Between Onset and Death
Physicia /Medica		disease or condition resulting in death)	a. Due to (or as a cons								YMON (4)
Examine	er e	1	Due to (or as a cons	aquanos on.							
	e e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence of):							
uted	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	C								
O, rexect an an rrial-tr		resulting in death) Last	Due to (or as a cons	equence of):							
Records, P.O. Box 68/60, The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical		d								
Box 68 leath certifics attending pt	Med	IF FEMALE:	23c. If yes, outcome of pre	nancy					234	Date of deliv	rerv
BOX eath cerr attendin for use	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 F	etal death 3	□Ectopic p					Month	Day Year
the de by the a	ysic	1 ☐ Yes 2 █Ño 9 ☐ Unknown	9□ Unknown	or death 5		poc.iiy/					
P.O. that the de detached			ontributing to death but not	resulting in the	underlying	cause given in	Part I.	23e. Did t	obacco use c	ontribute lo	the cause of death?
Records, F the law requires that the has been signed I age 2 should be det	d by							1 🗆 '	res 2□No	3 🗌 Pro	bably 4 Qunknown
cord w requir	Completed							24a. Was		b. Were aut	opsy findings available ompletion of cause of
Re lav he lav e has	E							autor perfo	rmed?	death?	
	a	25. Was case referred to medical				26.	Place of Dea	ath (Check only o	//		
ysiciu s cert direct	0.0		Hospital: 1 Inpatient 2	ER/Outpatie	ent 3 🗆 🗅	OA Other: 4	□ Nursing H	łome 5 ☐ Resi	dence 6 X	Other (Spec	My H-SAICE
o € = a	n:T	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	28b. Time Injury		28c. Injury at Work?		28d. Describe	how injury occ	curred	
Vision of Vital Attending Physician: r death. sctor: After this certific by the funeral director.	atio	1 ⊠Natural 5 Pending 2 Accident investigation	n		М	1 🗆 Yes	2 🗌 No				and Courte Maraches
Division of Attending after death. Director: After	Certification:	3 Suicide 6 Could not b 4 Homicide determined		kt home, farm, s ecify)	street, facto	ry, office		City or To		mber or Hui	ral Route Number,
urs af	Ce	200 O-450- 450- 450- 5	nysician: To the best of my	knowledge de-	ath coores	d at the time of	ate and place	and due to the	cause(s) and	manner as	stated.
Division (To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 15 Certifying Pt (Check only 2 Medical Exar	niner: On the basis of exame and manner stated.	nination and/or	investigatio	on, in my opinio	n, death occi	rred at the time,	date and place	e, and due	to the cause(s)
o the ortho	Med	29b. Signature and title of certifier	1-		1	9c. License nui			29d. Date sig		•
F 3 F 8) or a	MO		1	200	511	32	4.	6-	07
IP ,		30. Name and address of person who									
7		JORGE ALBREGO,	M.D., 598 CY	NWOOD D		EASTON	, MD	21601			
	State	31. Date filed (Month, Day Year)	32. Redistrar's S	ignature	Aren	*)					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Michaels Sr. Year Luther Henry /Medical APRIL 23 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIIMBERI AND MEMORIAL HOSPITAL ALLEGANY Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**√**2 M 2 □ F 87 Director 214-16-2600 Feb 1, 1920 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at MD Allegany Westernport, Md Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 Baughman Street IISA 21562 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 TyYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify White δ WW II Specify: 3 □Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Papermaker Westvaco permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygis Important; If item 27 is marked other any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wesley Michaels Effie Mae Spiker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14410 Amcelle St. Cresaptown, Md 21502 Nancy Davis/Dau Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Philos Cemetery 4/27/07 Westernport, Md 22. Name and Address of Facility Boal Funeral Home, 111 Church St Westernport, Md 21562 of Funeral Service Licenses Talenefle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ORONARY **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a gonniquence of requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1☐Live birth 2 Fetal death 3 □Ectopic pregnancy fo in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year signed by the a 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 : has autopsy perform certificate 2 1 No Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this မ funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f death. 2 ☐ Accident 6 ☐ Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number ustiano npleted cause of death (Item 23a) (Type, Print) BARRERA Memorial Ave Cumberland SODI

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 6 200

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended, #2, 10c For Per MD & FH, TCHD, 4/16/07, sbb Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 7:05 A M 2007 John Wesley Moaney /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Community Hospital
 Lanham
 P

 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth (Month, Day, Year)

 Months
 Days
 Hours
 Min.
 (Month, Day, Year)
 Prince George 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 127 M 2□ F 90 Director 215-01-5533 01-13-1917 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits artment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Lanham Lanham Maryland Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6929 Lamont Drive 20706 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ② Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: کر م 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be f. and Mental F. ပ္ Richard Moaney Clara Kellum 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Vivian Elizabeth Moaney/wife 6929 Lomont Drive, Lanham, Maryland 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Stephen's Cem. 04-14-2007 Unionville, Maryland 22. Name and Address of Facility Funeral Home Bennie Smith Funeral Home 426 Dover Street, Easton, Maryland 21601 21. Signature of Juneral Service 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 125 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to for an a noneague one officertificate be executed burial-transit Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as . IE FEMALE use a If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Įo. in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached for P.0. 9☐Unknown 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this ce completely filled in by the funeral direc 1 Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No 2 ER/Outpatient 3 DOA P 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signatur title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of perso no completed cause of death (Item 23a) (Type, Print) ldm Richam 9500 MO APULIC 31. Date filed (Month, Day, Year) APR 1 6 2007 🧗 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** APRIL 0903 M 2007 /Medical 4c. County of Death 4a / Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Medical AWSBUR Eninsula Kegional
Social Security Number 6. Ser WICOMICE enter If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 32-0360 Months 1 X M 2 □ F South Laroling Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced BLAC Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Mountaire Elementary/Secondary (0-12) College (1-4or 5+) /VeR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) COLPIN 29289 Naylor Miller Wife Md 21891 alisbuny 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City of Town, State 1 DSurial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) ringhill Mem Garden HebrON, 4-20-07 21 Signature of Fun The rv ce Licensee 22. Name and Address of Facility
Benne Smith 917 W. Isabella St nhie Salisbuer md 2180 Funeral Home omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fily one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final **Physician** disease or condition resulting in death) 30 m 100 /Medical Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to instructions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner sician and burial-transit the death certificate be executed Due to (or as a consequence of) Box 68760. the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day ned by the a 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9□Unknown 9 ☐ Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ۵ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica sompletely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Medical Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) QU 111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 320170 31. Date filed (Month, Day, Year) 32. Digistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dey **Physician** 2007 April 26, 2:55 A.M. Mary Margaret Nagle /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner Frederick Emmitsburg St. Vincent Care Center If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In vrs. lest birthdev) 8. Date of Birth (Month, Dev. Yeer) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖾 F June 21, 1912 Director Ireland 186-40-9542 Usuel Residence of Decedent Pagas 1 and 2 should be filad within 72 hours aftar daath with tha Maryland 10c. City, Town or Location 10e State 10b. County 10d. Inside City Limits 1⊠ Yes 2 No Director Emmitsburg Frederick MD 10g. Citizen of What Country? 10f. Zin Code 10e. Street end Number U.S.A. 335 South Seton Avenue Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 | Yes 2 10 No If Yes, Give Year or Dates: 14. Race - American I Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify: Š 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Religious Community Elementary/Secondary (0-12) College (1-4or 5+) Daughters of Charity Child Care 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Considine Michael Nagle 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sister Camilla Harant Religious Community member Dapartmant of Haalth a important: If Item 27 is any Injury or other trainings. 333 S. Seton Avenue, Emmitsburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ST. JOSEPH'S P.H. 4/28/2007 EMMITSBURG, MD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727 23a. Part /Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause og eech line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Physician/Medical Examiner To the Hospital or Attending Physician: The law requiras that tha daath cartificata be axecuted Sequentially list conditions, it my leading to in it. ed all cause. Enter Underlying Cause (Disease or injury Due to (or esse consequence of) Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last ue to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1 No To the Funeral Director: After this cartifica complately filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 1 Tyes 2 TX No 1 Inpatient 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No aftar daath. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end memor stated. 29a. Certifier

Registrar **DHMH 16 Rev 6/95**

State

29b. Signature end title of certifier

ALAN CARROLL, M.D.

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

310 S. SETON 32. Registrer's Signature

EMMITSBURG, MD. 21727

29d. Date signed (Month, Dey, Yeer)

APRIL 27, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** April 13, 2007 7:00 aM Esther Nechin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Woodside Center Silver Spring If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Yrs. 129-12-4265 Director Massachusetts June 11, 1914 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If liem 27 is marked other than "natural", or items 23s ~ ~ 000cc. 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2K No **Maryland** Chevy Chase Director Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20815 8100 Connecticut Avenue U.S.A. Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔼 No Specify Specify: 2 3 Nidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Elementary School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nathan Malmut Sarah Levant ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 800 Dale Drive, Silver_Spring, Maryland 20910 Matthew Nechin - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Mt. Lebanon Cemetery 4/15/2007 Adelphi, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Dicen de Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiomyopathy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician ar s the burial-t Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ed by t signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name and address

31. Date filed (Month, Day, Year)

APR

Lynne D. Diggs, M.D.,

18

2007

egistrar's Signature

10400 Connecticut Avenue,

of person who completed cause of death (Item 23a) (Type, Phrt

Division or Vital Records, P.O. Box 68760

D34472

#206, Kensington, Maryland

April 14, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Ruth Hankins Nesbitt 16:35 M April 12 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 □XF Director 577-36-2872 87 Apr. 14, 1919 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 □ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15300 Wallbrook Ct. 20906 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify þ Black 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Attorney Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Charles T. Hankins Nannie Dodson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy H. Overby/Sister 1415 Tuckerman St., NW #318, Wash., DC 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 4/20/2007 Brentwood, MD 21. Signature of Furieral Service Licensee, 22. Name and Address of Facility Stewart Funeral Home 11 4001 Benning Rd., NE Wash., DC 20019 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical attending for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of cepifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
APR 1 8 2007

C01-016

32. Registrar's Signature

BC1082039

18109

4 (13/07

Prence Phillips Dr

Please Type or Print in Black Indelible Ink Engure All Co.

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State	f Manda	nd / Da		lookh on	d Mont	- L L L	.:	2.0	1

State of Maryland / Department of Health and Mental Hygiene 🔱 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician Year SUSAN McLANE NELSON April 11 2007 6:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7008 Pleasant Valley Crt. Seat Pleasant Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 🖾 F 89 Yrc Director 578-30-6063 1917 St. George, SC Usual Residence of Decedent the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ehow empinjury or other traumatic event, the Medical Examinat must be notified at once. 10b. County 10d. Inside City Limits Maryland Prince George's Seat Pleasant X Yes 2 No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 7008 Pleasant Valley Court 20743 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Spacify: Black 1 ☐ Yes 2 No Specify: þ 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Cafeteria Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph McLane Ennis Dessisso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Claytor/Friend 7006 Pleasant Valley Crt., Seat Pleasant, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Washington National Apr. 17 2007 4 ☐ Donation 5 ☐ Other (Specify) Suitland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, Maryland 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2 Years Chronic Respiratory Failure /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Lung Disease 5 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by þ Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? The law 24a. Was an autopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2X No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ပ 1 DYes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 XNatural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation M 1 Tes 2 No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check unit) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D16273 MD 4/13/07 address of person who completed cause Texth (Item 23a) (Type, Print) Revathy Murthy, MD, 6130 Landover Road, Cheverly, Maryland 20785 32. Registrar's Signat State Registrar

		For State Registrar	State	of Man		artment of artificate of			-	giene Reg. No	Z U U /	14191
		1. Decedent's Name (First, Middle,	Last)						2. Date of De	ath		3. Time of Death
Physicia		Mae Louise Nic	holson						Month April	22 Da	2007	8:00 A.M
/Medic: Examine		4a. Facility Name (If not institution,	give street and no	umber)		4b. City, Town,	or Locati	on of Death			. County of Deat	
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Funeral			6. Sex		n yrs. last birthday	If Under 1 Year	If Un	der 24 Hrs.	8. Date of Bin	th	9 Birt	nplece (State or Foreign
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	dr.	Elementary/Secondary (0-12)	T	(1-4or 5+)	life.	e kind of work done DO NOT use retire	rd)		•			
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should be filed within 72 hours after death with the Maryland nd Mental Hygiene. Imarked other then "neturel", or iteme 23e or 28a-f show imatic event, the Medical Examinar must be notified at	Be	17. Father's Name (First, Middle, L	.ast)				18. Mo	other's Name	(First, Middle,	, Maidei	n Sumame)	
Menid	ို	Emory Shilling	burg				Ве	essie :	Steyer			
permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. International Hygiene important: If Item 27 is marked other then "neturel", or Iteme 23e or 28a-f ehow eny Injury or other treumatic event, the Madical Examinational be notified at once.		19a. Informant's Name/Relationsh	ip (Type, Print)			ing Address (Stree						
and and n 27		Wayne Nicholso	n, Son			Fingerbo	ard	Road,	0aklan	ıd, l	MD 21550	
- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1		20a. Method of Disposition 1X Burial 2 □ Cremation	3 □Bamayal from		20b. Place of Disp cemetery, cre	osition (Name of matory or other pla	ice)	D	ate	20c. L	ocation - City or	Town, State
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mit.		21. Signature of Funeral Service L	icensee		2	2. Name and Addr	ess of Fa	acility				
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		23a. Part1. Enter the disease, or a shock, or heart failure. List of	complications that	caused the							21330	Approximate
Dhomistan		Immediate Cause (Final		10								Interval Between Onset and Death
Physician : /Medical	1	disease or condition resulting in death)	a. Dua te	pne	umoni	4						2 days
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2 8 6 0	g								24a. Was autop		24b. Were au	topsy findings available ompletion of cause of
relcien: The lew s certificate has b firector, page 2 s	Completed								perfo 1 ☐ Yes	rmed? 2 ☑ No	death?	2 □ No
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yslc is ce dire	၉	1 ☐ Yes 2 No	Hospital:	Inpatient	2 ER/Outpatie	nt 3□ DOA Ot	эөг: 4□	Nursing Hon	ne 5□Resid	dence	6 ☐Other (Spec	ufy)
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Atta	≘	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determine	ned 289. Plac	e of Injury	- At home, farm, s	reet, factory, office		2	28f. Location (S City or Tox	Street a	nd Number or Ru	ral Route Number,
D d d d	Certification:		Dunk	ang, otc. (t	оросну)				City of 101	WII, State	9)	
hour hour nare y fille		29a. Certifier 1 Certifying	Physician: To th	e best of n	ny knowledge, dea	th occurred at the ti	me, date	and place, a	and due to the	cause(s) and manner as	stated.
To the Hospital or Attanding Physicien: The lew requires that the death certification 24 hours after death. To the Funaral Director: After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use as	edicai	(Check only 2 Medical E	and ma	hasis of ex nner stated	amination and/or ii I.	nvestigation, in my	opinion, e	death occurre	ed at the time,	date an	d place, and due	to the cause(s)
To ti To ti Comp	ž	29b. Signature and title of certifier				29c. Licen	se numb	er		29d. Da	te signed (Month	, Day, Year)
		Malle	Mann	000-	MD	J D	00:	257	159	An	11/22	2007
	1	30. Name and address of person v	who completed cau	se of deat	h (Item 23a) (Type	Print)	- 6	- 6	- 1	P	MD 21	
	5	Walter K.	Naum		MI	10 Box	24	-7 A	ccide	4+	M/ 2,	520
Stat	e	31. Date filed (Month, Day, Year)	32.	R ég istrar's	Signature			1 1	-,-,-,		.,, -,	-
Registra		APR 2	5 2007	200000	c 15 1	Coall B						

			For State Registrar	\$	State of N	/larylan		artmen rtificat			and M		giene Reg. No	2111117	14192	
	Physici	an	Decedent's Name (First, Mid	dle, Last)	Irvi	n Nicol						2. Date of De Month	path Day ril 20,	y Year	3. Time of Death	
S	/Medic Examin		4a. Facility Name (If not instituti	on, give stre				4b. City.	Town, or	Location of	of Death	710		County of Dea		-
	LAUIIII	938' 24	100	Honeys	uckle Lan	e Apt. 2	09			I	Frostbu	ırg		Al	legany	
70 c	Funeral		5. Social Security Number	6. Sex	7. A		last birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Bir	hplace (State or Foreign	7
	Director		215-20-6925 Usual Residence of Decedent	1 (42)	. 201	79	Yrs.					August	18, 192	27	Maryland	_
	land ow		10a. State 10b. Coun	ty		10c. Cit	y, Town or Lo	cation					-		10d. fnside City Limits	
	Many	ţ	Maryland	Allega	ny					Frostb	urg				1 XYes 2 □ No	
	th the	lrec	10e. Street and Number					10f. Zip	Code				10g. Cit	tizen of What Co	ountry?	
	ath wi	rai	100 Hon		Lane Ap					2153					S.A.	_
	er de	nue	11. Marital Status 1 Never Married 2 ☐ Ma		Was Deceder Armed Force: 1XYes 2[s?	.S. 13.	Was Deced f Yes, spec	dent of Hi cify Cuba	spanic Ori n, Mexican	gin? (Spe 1, Puerto F	city Yes or No Rican, etc.))-	14. Race - Ame Black, Whit		
36	irs aft	by F	3 Widowed 4 Divorce		If Yes, Give Year or Dates		15	1 🗆 Yes	2 X No	Specify:				Specify:	White	
ğ	be filed within 72 hours after death with the Maryland ttal Hygiene. Id other than "naturel", or items 23e or 28e-1 ehow event, the Medical Examinal must be notified at	Completed by Funeral Director	15. Decede (Specify only high	ent's Educat	ion		16a. Dece	dent's Usua	al Occupa	ation	t of worker	10	16b. K	and of Business		_
215	within 7 ene. than "r	npie	Elementary/Secondary (0-12		College (1-40	r 5+)	life.	DO NOT u		during mos		<i>'</i> 9				
121	e filed within al Hygiene. I other than '	S	17. Father's Name (First, Middle	a / act)	0		<u></u>		M	lillwrig		(First, Middle	Maiden		mobile	_
anc	nntal h	To Be	17. Patriot S Ivanie (First, Wilder		as Francis	Nicol				10. 14101.110	, 3 manio			setta Grove		
Ž	should be and Mental marked o umatic eve	ř	19a. fnformant's Name/Refation			111001	19b. Mailir	ng Address	(Street a	and Numbe	er or Rura			or Town, State,		_
ž	alth ar 27 is ar trau		Jacki I	Kerr - N	iece			1110	3 Wels	sh Hill	Road S	S.W., Fro	stburg	g, Maryland	d, 21532	
ore,	ges 1 and 2 should it of Health and Mer if Item 27 is marke or other traumatic		20a. Method of Disposition 1 □ Burial 2 ★Cremation	3 Den	noval from Sta		Place of Dispo emetery, crea	sition (Nam matory or o	ne <i>of</i> other plac	Θ)		ate April 21,	20c. Lo	ocation - City or	Town, State	
Ĕ	nit. Pages bartment of l ortant: If it injury or o		4 □Donation 5 □Other	(Specify)	ioval ilom Sta		Cumbe	erland C	Crema	tory		2007	(Cumberlan	d. Maryland	
Baltimore, Maryland 21215-0036	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	e Licensee	_		22	2. Name ar	d Addres	s of Facilit Eichho	y orn-Mc	Kenzie F	uneral	l Home P.A	Λ.	
	40 2 e 0		23a, Part1. Enter the disease,	KINZ	el	od the deat	h Do not on	or the med	8 la of divini	East N	1ain St	reet, Lon	aconin	ng, MD 21:	539 Approximate	_
	Physician		shock, or heart failure. Li fmmediate Cause (Final disease or condition	st only one	cause on each	line.	10	1RR	V11	MI	4.	i roopiiatory c			Interval Between Onset and Death	
400	/Medical Examiner		resulting in death)	(a.	Due to (or	as a conseq	uence of):		7							
r	LXdiffile	25	Sequentially list conditions,	b	Due to (or	as a conseq	nence of):	art	218	ease	ρ				275	_
	red	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	≺	200 10 (0)	20 4 0011004	33733 377.									
Ć	execu in and ial-tra	Еха	that initiated events resulting in death) Last	C	Due to (or a	as a conseq	uence of):									
8760,	death certificate be executed e attending physicien and rd for use as the burial-transit	cal		d												_
9	artifica ing ph e as tl		IF FEMALE:													
Вох	death certifica attending phate as to the as t	Physician/Med	23b. Was decedent pregnant in the past 12 months?	230	. ff yes, outcon 1 ☐ Live birth	2 Feta	Ideath 3	Ectopic p						23d. Date of de Month	livery Day Year	
P.0.	at the de by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnant 9□ Unknown		eam 5L	Other (sp	<i>өспу)</i>							
	law requires that the as been signed by th 2 should be detache		Part II. Other significant condi	tions contri	buting to death	but not res	ulting in the u	nderlying o	ause give	en in Part I	. ,	23e. Did	tobacco (use contribute t	the cause of death?	
Division of Vital Records,	w requires been sign should be	ed by	Myha Chisio	2,70	bocke	House	Chyn	u 1	Cros	fai	lyl	W	Yes 2	□No 3□P	robably 4 □Unknown	
တ္ထ	e law re has bee je 2 sho	Completed	reedis	didy	FI U	Aliss						24a. Was		24b. Were a	utopsy findings available	*
<u>~</u>	The ate h	Com										perfe	ormed? 2 No	death?		
/ita	sician: Th certificate irector, peg	Be (25. Was case referred to medie examiner?						100	•	of Death	(Check only	опе)			-
o	y S	To.	1 ☐ Yes 2 X No 27. Manner of Death	Hos	apital: 1 ☐ fnpa 28a. Date of Ir		ER/Outpatier 28b. Time o			4 L NU	ursing Hon	ne 5 Res 28d. Describe		6 Other (Spe	ocify)	
uo	ding l h. After funer	tion	1 Natural 5 ☐ Pen	ding stigation	(Month, I	Day Year)	Infury	м (8c. Injun Worl	k? Yes 2 ☐		ou. Describe	now inju	ny occurred		
/isi	if or Attending after deeth. I Director: After d in by the funer	ertification;	3 ☐ Suicide 6 ☐ Cou	-	28e. Place of	Injury - At h	ome, farm, st								ural Route Number,	-
á	s after s afte	Cert	4 Homicide		building,	etc. (Specil	Y)					City or To	wn, State	8)		
	To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: Atter th completely filled in by the funeral	ledical ((Check only 2 Medic		r: On the basis	of examina								and manner a	s stated. e to the cause(s)	
	the Ithin 24 the Ithe Ithe Ithe Ithe Ithe Ithe Ithe	Medi	one) 29b. Signature and title of certi		and manner								10.1.5			_
\	To To		Signature and title or cent	N.A.	Karit	las		2.5	5	19	718		1	Abeil.	15t 2007	
			30. Name and address of person	on who com	pleted cause of	of death (Iter	n 23a) (Tvne	Print)	9	//	2.0			11100	/	
	VA	2	VA Ranit	han.	M.D.	517	E. ol) tow	n R	oad,	Cun	berlan	d. N	ND 215	od Cod	
B	Sta		31. Date filed (Month, Day, Yea	ar)	32. Re gi	strar's Signa	ature	A 40			~~~					
	Regist		AFR A	· 佐 / III	1 1 1 1 2 1 2 1	BEARIN O	A 100 A	TOTAL BASE	EP							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8:10 рм **Physician** MILES POWERS 21 2007 April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Bel Air Upper Chesapeake Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 12/21/1920 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex Funeral Months **№** M 2 🗆 F North Carolina 240-28-3483 86 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No MD Harford Darlington Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21034 USA 856 Priestford Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: White Maryland 21215-0036 Specify: Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Agriculture Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be J. Oscar Powers Mary Magdalene Adams ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29891 Grasswell Drive, Easton, Md Bradley H. Powers/Son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If Ite any injury or of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Important: If any injury or once. Bel Air Mem. Gardens | 4/26/2007 Bel Air, MD 22. Name and Address of Facility of Funeral Service Licenses 17314 Harkins Funeral Home, Inc., Delta, PA Anti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** Due to ()r = a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last a consequence of): Due to (r Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): 68760. þe Physician/Medical Box IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death signed by the Ö 9 Unknown Δ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 2 No Division or Vital Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3□ DOA Certification: To Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation spital or Attendil ours after death. neral Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

10 State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of portifier

Bu Registrar's Signature MAY 0 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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POWER

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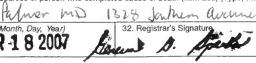
04-22-2007

			State of Maryland / Departr	ment of Health and M icate of Death	ental Hygier	/ 11111	9
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia		Gladys Louise PALMER		April 18		9:42 a M
	/Medic Examin			. City, Town, or Location of Death	4	c. County of Death	
70.	LAGITIII.		Julia Manor Nursing Home	Hagerstown		Washingto	n
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If	Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthp	place (State or Foreign
	Director		220–26–5002 1 M 2 N F 76 Yrs. M	Ortus Days Frours Will.	May 14 19		
	pc ,		Usual Residence of Decedent 10a State 10b County 10c City, Town or Location			Jay Year 3. Time of De 2007 9:42 4c. County of Death Washington Year) 9. Birthplace (State or F County) 1930 Pennsylvania 10d. Inside City 1 yes 2 g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White 6b. Kind of Business/Industry Manufacturer aiden Sumame) an City or Town, State, Zip Code) pring, Md. 21722 oc. Location - City or Town, State a erstown, Md. 21740 st, Approximate Interval Batwe Onset and De 23d. Date of delivery Month Day Ye acco use contribute to the cause of dease 2 No 3 Probably 4 Dease 2 No 3 Probab	
	arylai shov	<u>_</u>	10a. State 10b. County 10c. City, Town or Location	on			1 ☐ Yes 2X No
	8a-f	cto	Maryland Washington Hagers			200	
	or 2	Director		10f. Zip Code	10g. C		ntry ?
	ath v		16505 Fairview Road	21740	- Was at No		can Indian
	er de	Funeral		Decedent of Hispanic Origin? (Spo es, specify Cuban, Mexican, Puerto	Rican, etc.)		
36	rs aff	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No If Yes, Give 1 ☐ 3 📆 Widowed 4 ☐ Divorced Year or Dates:	Yes 21 No Specify:		Specify: Wh	ite
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-1 show the M. Jical Ex., niher mast be notified at		15 Decedent's Education 16a Decedent	's Usual Occupation	16b.	Kind of Business/In	dustry
75	in 72 n "ne	Completed	life. DO	d of work done during most of work NOT use retired)	ng		
22	iene r tha	Eo		cical wiring	Ma	nufacture	r
헏	e filed withial Hygiene. I other than	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	a (First, Middle, Maid	en Sumame)	
<u>a</u>	2 should be to and Mental I is marked or raumatic eve	2	Elmer Ray Sowers	Edna Ga	il Heckmar	L	
ary	shot and A s ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	Address (Street and Number or Run	al Route Number, Cit	y or Town, State, Zip	Code)
-	alth 27						
J.	permit. Pages 1 a Department of He Important: If item any injury or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State	on (Name of ory or other place)	Date 20c.	Location - City or To	own, State
Ĕ	Page nent (int: If			Mem. Park 2/20	/07 Ha	erstown,	Md. 21740
Baltimore,	mit.					neral Hom	ne
m	8 8 1 8		Dadt Museue 415	E. Wilson Blvd	. Hagersto	wn, Md. 2	1740
	*		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	he mode of dying, such as cardiac	or respiratory arrest,		Interval Between
1	Pnysician		Immediate Cause (Final disease or condition	Kidney D	iseas	_	Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):	*		4	
	Examiner		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	nsion			
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter University Ly Cause (Disease or injury	mellitu.	,	2	
	be executed sician and burial-transit	Examiner	that initiated events	Mellina)		
Ö,	e exe ian a urial-		resulting in death) Last Due to (or as a consequence of):				
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dicai	d				
9	ing plass t	Med	IF FEMALE:				
Вох	leath certific attending p i for use as	Physician/Me	23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome or pregnancy 1 Live birth 2 Fetal death 3 Ec	topic pregnancy			*
	at the dea by the ai	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Oi	ther (specify)			
P.0	The law requires that the ste has been signed by th bage 2 should be detache	Phy	Part II. Other significant conditions contributing to death but not resulting in the unde	stving cause given in Part I	23e. Did tobaco	o use contribute to t	the cause of death?
	res tha signed I be det	ρ	Part II. Other significant conditions contributing to death but not resulting in the dide	mying cause given in raiti.	1		
0.0	w require been sign	ted		·	-		
ec	elaw hasb je 2 sl	npie			24a. Was an autopsy performed	prior to co	opsy findings available empletion of cause of
of Vital Records,		Completed					2□ No
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	Othor	h (Check only one)		-
of C	shysi this c	မ	1 198 2 NO 1 Inpatient 2 ENOutpatient	3 DOA 4 Avursing Ho	ome 5 Residence 28d. Describe how in		fy)
	ing P	lon:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe flow ii	ilary occurred	
Sic	ttendii death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be		28f. Location (Street	and Number or Rur	al Route Number
Division	if or Attending after death. I Director: After d in by the fune	Certification;	3 Suicide determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	, factory, office	City or Town, St		
٢	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a, Certifier 1☐ Certifying Physician: To the best of my knowledge, death or	coursed at the time, date and place	and due to the cause	a(s) and manner as	stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a, Certifier (Check only one) Check only one) And manner stated.				
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
	F 3 F 8		Frank muchan	706034	96	041.21	07
,			30. Name and address of person who completed cause of death (Item 23a) (Type, Printer)		ral C	+	,
6	4-4		FARID WYR SHED	11		mp:	21740
	-	ate		Hoge	154.41	15/ 15	21175
4	Regist		31. Date filed (Month Par Year) 2007 32. Segistrar's Signature	NA .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** April 15 2007 Annie Mae Parson 8:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince George's Clinton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 ☐ M 2 🖾 F Director 249-36-0384 3, 1929 Feb. South Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Director Maryland Prince George's Ft. Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygene. ant if item 27 is marked other than "natural", or items 23a or ant if item 27 is marked other than "natural", or items 25a or ury or of their traumatic event, the Medical Examiner must be rury or other traumatic event, the Medical Examiner must be r 6801 Bock Road, Apt. 133 20744 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Completed by 3 ☑ Widowed 4 ☐ Divorced American 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Caretaker Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charlie Harrison, Sr. Eva Price ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Par-Shana D. Parson/Daughter 6604 Atwood St., #4, District Heights, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State Department of important: if any injury or once. 4 ☐Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 4/24/2007 Cheltenham, MD 21. Signature of Furleral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 23a. Part1. En 4r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Canse (Final disease or continuon resulting in death) My Caril Hente **Physician** /Medical Due to (or as a cons ence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as 2 consequence of: requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Id be detached f 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, δ Conges hvi tar 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed After this certificate 2 **□**1√0 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2**☑** No 1 Thipatient 2 ER/Outpatient 3 DOA 2 within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division (Month, Day Year) 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 6 To the Hospital within 24 hours a To the Funeral C the Hospitai 📭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)
APR-1 8 2007



MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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10055120

Surte 310

Washing

Road Construction Company Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katherine Adams Alfred Raymond Pilkerton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 29258 All Faith Church Road, Mechanicsville, Maryland 20659 Mary Lee Pilkerton / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Important: If any injury o Trinity Memorial Gardens April 28,2007 | Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Rome, F.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Y575 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner metastal, c Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine 78415 COVONS, Completed by Physician/Medical E FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate 1□ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1/1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA P within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0061719 April, 25, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAH ASSOC 24035 THREE NOTCH ROAD HOLLYWOOD MARYLAND 20636 DHANANJAY BHAVSAR M.D. 32. Pogistrar's Signature 31. Date filed (Month, Day, Year) APR 2 5 State 2007 Registrar 1000 DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) 10:54 A M APRIL 24 2007 Joseph Raymond Pilkerton 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) St. Marv's Leonardtown St. Mary's Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number Months Days Hours 1 X M 2 □ F 90 Yrs. May 15,1916 Maryland 213-22-1283 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No Maryland St. Mary's Mechanicsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 29258 All Faith Church Road 20659 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 **X** No If Yes, Give Year or Dates: 1 ☐ Never Married 2 【▼ Married 1 ☐ Yes 2 💢 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1:42 AM 2007 Anna Carol April 27, 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Allegany Moran Manor Health Care Center Westernport 8. Date of Birth (Month, Oay, Yea Apr. 9, 1 5. Social Security Number 7. Age (In vrs. jast birthday) 9. Birthplace (State or Foreign Days 1 ☐ M 2 🕱 F Hours 60 Yrs. Apr. 232-72-9863 Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits 10b County 1 ☐ Yes 2 No W Hampshire Augusta 10e. Street and Number 10g. Citizen of What Country? HC-71 Box 130 C <u> 26704</u> USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 Toivorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker **Housekeeping** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Robert Ross Sada Grace Grapes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy G. Butler (daughter) P.O. Box 213 Clearbrook, VA 22624 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 4/27/07 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Scarpelli F.H. PA Cresaptown, MD 21. Signa e of Funeral Service License 22. Name and Address of Facility McKee Funeral Home Inc. P.O. Box 270 Augusta, WV 26704 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) My & contral 30 minutes Due to (or as a consequence of Conona Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner

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Certification:

Physician

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Item 27 is marked other than "naturel", or Items 23s or 28s-f show other traumatic event, it is Madical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after I Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Item eny injury or other traumatic event, the Medical Exemi

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Day Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Onknown

24a. Was an autopsy 1 ☐ Yes 2 40 26. Place of Death Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2□ No

Year

orbid 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Aursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

3 Suicide 4 \ Homicide 29a. Certifier

Natural 2 Accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number 721244 29d. Date signed (Month, Day, Year)

wesus H. Tan

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Frostburg, Md.

State Registrar

MAY 0 2 2007

6 □ Could not be

determined



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 12. 2007 **Physician** Muriel M. Rudge 12:38 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Adelphi Hillhaven Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 K F 79 220-34-9198 May 18, Director 1927 England Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 Y No Director Maryland Montgomery Silver Spring 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20904 3125 Gracefield Road United Kingdom Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 □ Divorced White "natural", Year or Dates Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 17 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Printing Proofreader 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental B Wilford James Rudge Margaret Frances Richardson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
any injury or other trau Kenneth F. Baer-Durable POA 20011 Tanbark Rd., Brinklow, Maryland 20862 Baltimore. 20b. Place of Disposition (Name of Ft-cematery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 4/20/2007 Brentwood, Maryland Crematory 21. Signature of Funeral Service Licenses Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Days **Physician** Uremia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Years Chronic Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760 pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown this certificate has been sal director, page 2 should Completed Multiple Myeloma 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? res 24 No Division or Vital 1□ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural Injury 5 Pending To the Hospital or Attendia within 24 hours after death.
To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

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Bertha	Christine

Bertha Christine		SSOS I- For State	State	of Maryla	and / Depa	artment o			Menta	al Hy	giene	J	gra.	5	F77
		Registrar 1. Decedent's Name (First	Middle Lee		Ce	runcate C	Dea	ui		1	2. Date of Dea	eg. No.	-21		3. Time of Death
Physicia Medical Examir		Bertha Chris								ľ	Month April 12, 2	Day	Year	ľ	1922 hrs
Q-		4a. Facility Name (if not in Suburban Hospit		e street and nu	imber)		•	, Town, or L nesda	ocation of	Death			County of I		
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Funeral Director		577-10-1791	1	M 2 X F	89	Υ	Mon			Min.	Sept. 2	•	T _F	oreign Cou	Washington, DC
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r 28a-	Director	10e. Street and Number					10f. Z	ip Code			1		en of What	Count	ry?
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ours a atura	d by	15. Decedent's Educatio	n (Specify or			16a. Deced		al Occupati				16b. Ki	ind of Busir	ness/In	dustry
Baltimore, MD 21215-0036 germit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary	(0-12)	College (*	1-4 or 5+)	1	nemake		20 110 1 0	ioo rotare	50,	O	wn Home	•	
5-0036 iled within 7 Hygiene. I other than	<u>E</u>	17. Father's Name (First,	Middle Last					- 17	8.Mother's	Name	(First, Middle,	Maiden S	Surname)		
215- be filed atal Hy rked of	Bec	Christos Atha									aharo Ch				
213 ould b 1 Men s marl	리	19a. Informant's Name/Re	lationship (T	ype, Print)		19b. Maili	ng Addre	ss (Street	and Numb	er or R	ural Route Nur	nber, Cit	y or Town,	State,	Zip Code)
MD d 2 shc Ith and n 27 is aumati		Jason Rous		n						Whea	ton, Mar				
MOre, Pages 1 an ient of Hea nut: If iten		20a. Method of Disposition 1 Burial 2 Cree		Removal f		Place of Disp crematory or				\ \ \ \	Date	20c. L	.ocation - C	ity or 1	rown, State
imc Page ment of		4 Donation 5 O	ther Specify			tropolita					13,			ndri	a, Virginia _
Baltil permit Departm Imports		21. Signature of Funeral S	Service Licer	see							eral Hom				
Physician		23a. Par I. Enter the dise	ase, or comp	lications that	aused the deat						respiratory are				Approximate Interval
/Medical		failute. List only one Immediate Cause (Final o		ach line. Multiple Inj	iuries										Between Onset and Death
≒xaminer		or condition resulting in d			a consequence	of):									
"Je-ser"	ē	Sequentially list condition if any, leading to immedia	s, b. te	Due to (or as	a consequence	of):									
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ansit		events resulting in death)	Last d.	Due to (or as a	a consequence	01):									
OX 68760, eath certificate be executed attending physician and for use as the burial - transi	dical	UNPENDED		AMENDED											
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K 68 1 certif ending use as	sician/Me	past 12 months?			nant at time of		Fetal deat Other (SI		Ectopic	pregnar	icy		Month	U	ay Year
Box e death c the atten ed for us	hysi	1 Yes 2 V No 9		J OHKI	own										E
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the fumeral director, page 2 should be detached for use as the b	by P	Part II. Other significant	conditions	contributing t	o death but not	resulting in the	e underlyi	ng cause g	iven in Par	rt I.					he cause of death? ably 4 Unknown
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of Vital Records, ng Physician: The law require Ner this certificate has been si meral director, page 2 should b	o Be	examiner? 1 ✓ Yes 2	, lī	Hospital:	Inpatient 2	ER/Outpatie	nt 3		Other ₄		g Home 5	Reside	nce 6	Other	
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ivision I or Attendi after death. Director:	ication	1 Natural 5 2 Accident	Pending Investigat	ion		1610 hrs			′es 2 ✓	No					
Division pital or Attendio ours after death. ceral Director: A	Certific	3 Suicide 6	Could not determine	be	ce of Injury - At I		reet, facto	ory, office b	uilding, etc		28f. Location (or Town, Randolph Ro	State)			al Route Number, City
Di Hospital 24 hours a Funeral I		4 Homicide 29a. Certifier		(9,5 5 5)	Local Stre		urred at t	the time da	ote and nlar	L					
To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only one) 2 Medic	al Examine	r:On the basis	of examination	and/or investig	ation, in	my opinion	, death occ	curred at	t the time, date	and pla	ce, and du	e to the	e cause(s)
7 . S	Me	29b. Signature and title of	certifier	and manner	siaicu.		2	29c. Licens	e number			29d. [Date signed	d (Mor	nth, Day, Year)
MIO		auss	2					0.0.1	M.E.			Apri	il 13, 200)7	
,		30. Name and address of			,	,	Ct	Daltin	- MD	24224		•			
		Ana Rubio MD.		nt Medical	Examiner egistrar's Signa	111 Penn	Street	, Baitimo	ore, MD 2	21201					
St	ate	31. Date filed (Maph Da)	18 20	07 34	Cogracial a Signa	K do	anti-	9							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - State AMEND#29dper MD4/19/07, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 15, 2007 Richardson 1:05a M Jerry Μ. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Althea Woodland Nursing Home Silver Spring If Under 1 Year | If Under 24 Hrs. | Date of Birth (Month, Day, Year) 5/19/1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 1 X M 2 □ F 439-09-3385 87 Louisiana Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Montgomery Silver Spring 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20901 1000 Daleview Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces?

1 XYes 2 No 1945 —
If Yes, Give
Year or Dates: 1947 Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Black Specify: Specify: 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Truck Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unobtainable unobtainable 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Springdale, Maryland 20774 3518 Jeff Road Helen Lewis/ Friend-P.O.A. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State Chesapeake Crem. 4/18/2007 Peltsville, Md. 4 □ Donation 5 □ Other (Specify) PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and De Immediate Cause (Final disease or condition resulting in death) dry vona Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Line Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 2 No 1□ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

Director

Funeral

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Completed

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filed within 72 hours after death with Hygiene. r than "natural", or items 23a or the Medical Examiner must be

marked other than

Department of Health and Mental I Important; if Item 27 is marked of any Injury or other traumatic eve Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

certificate be

Examiner burial-tran attending physician the use as for the

Physician/Medical þ

Certification:

Medical

signed by the Completed I page 2 director, Be ဥ funeral

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within 24 hours af To the Funeral D

25. Was case referred to medical examiner? 2 No 1 ☐ Yes

27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide 4 Homicide

5 ☐ Pending investigation 6 ☐ Could not be

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Iniury

28c. Injury at Work?

1 🗷 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 □ Yes 2 □ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

30 Name and address

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

of person who completed cause of death (Item 23a) (Tweet

29c. License number

20 757

State Registrar

31. Date filed (Month, Day, Year) 18

203 egistrar's Signature

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within 24 hours at To the Funeral D

State Registrar

Medical

29a. Certifier

(Check only one) 29b. Signature and tit

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basic of examination and/or investigation in my online, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day ROMANSERRA **Physician** GREGORIO 8:25 A APRIL 2007 16, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's 4323 Monroe Street Colmar Manor If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Ye May 11, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 581-56-6660 1 X M 2 □ F Arecibo, PR 76 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d Inside City Limits 10a. State 28a-f show the Medical Examiner must be notified at tx☐Yes 2☐No Maryland | Prince George's Colmar Manor 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20722 USA 4323 Monroe Street Items 23a death Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Amed Folces:

1 Ves 2 No
If Yes, Give
Year or Dates: KOREAN 1 Never Married 2 Marned Puerto Specify Puerto Rican ŏ 1⊠Yes 2□ No Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Rican "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Veterans e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Medical Center Housekeeping 12 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Deportment of Health and Mental Hy Important: If Item 27 is marked other eny liquy or other traumatic event 900g. 17. Father's Name (First, Middle, Last) Be Francisca Serrano Gregorio Roman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Retationship (Type, Print) Divina Soto Roman - Wife 4323 Monroe St., Colmar Manor, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial / 2 ☐ Cremation 3 ☐ Removal from State 4/20/2007 Arecibo, Puerto Rico Bajadero Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Mehille (Acre Mc1491 Gasch's Funeral Home, P.A. 22a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Hyattsville, MD 20781 Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOVASCULAR DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached f ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼ No 24a. Was an page 2 s has 1 ☐ Yes 2 💢 No Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitat: 1 ☐ Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ٩ this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: After 5 Pending investigation 1 Yes 2 No 2 Accident Director: 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours To the Funerel Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier APRIL 16, 2007 #D31099 30. Name and address of person who completed cause of death (Nem 23a) (Type Print)

ERIC S. NYLEN, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year, APR :1 8 200)

ORIGINAL

32. Registrar's Signatur

			For State of Wallyland / Department of the Partment of the Par	rtificate of Death		. No. 2007	14204
	Physicia	an.	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	/Medic		Violet Thelma Rudasill		April 24		1:01 p ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
Same.	A		St. Mary's Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Leonardtown If Under 1 Year If Under 24 Hrs.	8. Date of Birth	St. Mary's	lace (State or Foreign
l	Funeral Director		214-28-8900 1 M 2 XF 91 Yrs. Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	3 1 E	ington, DC
	land ow it		10a. State 10b. County 10c. City, Town or Lo	cation		1	0d. Inside City Limits
	Mary -f sho fied a	tor	Maryland St. Mary's St. Mary'	e City			1 ☐ Yes 2 XNo
	r 28a	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cour	ntry?
	th wit 23a o Ist be		47683 Lucas Cove Road	20686	Uı	nited State	es
	ems ems	Funeral		Was Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto		14. Race - Americ Black, White,	an Indian,
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 No Specify:		Specify: Whi	
2-0	72 ho natur dical	eted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16	6b. Kind of Business/In	dustry
2	ithin ne. han " e Mec	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)				
2	led w Hygiei her ti	S	12 Homen 17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	Own Home	
anc	be ital	Be				,	
$\frac{2}{5}$	hould d Me mark matic	은	William Franklin Shelton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailli	Laura LO ng Address (Street and Number or Rui	uise Char		Code)
Z	and 2 s ealth ar n 27 ls ier trau		, , , ,	Hollywood Road,		,	,
ē,			20a. Method of Disposition 20b. Place of Disposition			Oc. Location - City or To	
Ë	Pages nent of Hant of Hant of Hant of Hant of Hant or of hand or o		1 Mg Burial 2 □ Cremation 3 □ Removal from State	piscopal Cem 04/2	7/2007 S	t. Marv's	City, MD
Baltimore,	permit. Page Department of Important: If any injury or once,			2. Name and Address of Facility Bri			
<u></u>	8 3 2 6	11	Edward N. Brinsfield, JR. M00052 22	2955 Hollywood Roa	d, Leonar	dtown, MD	20650
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Atriovatricular	association			Onset and Death
7	/Medical Examiner		Due to (or as a consequence of):				
Ē		-	Sequentially list conditions, if any, leading to immediate cause. Enter University in the content of the conten				
	rted	Examiner	Cause (Disease or injury			1.00	
Ć,	execu n and ial-tra	Exal	that initiated events c Due to (or as a consequence of):				· · · · · · · · · · · · · · · · · · ·
68760,	tificate be executed ig physician and as the burial-transit	edical	d				
			IF FEMALE.				
Вох	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Physician//	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	⊒Ectopic pregnancy		23d. Date of deliver	
E	e dea the at ned fo	sici		Other (specify)		WOITE	Day Year
P.0.	hat th d by t letach	Phy	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I	23e. Did toba	cco use contribute to t	ne cause of death?
Vital Records,	ires ti signe	by		ndonying dadoo givon iiri airi.	1 ☐ Yes		pably 4 □Unknown
Ö	requ	eted	Renal failure Hyperkalenia		4	1	
Rec	2 83 20	Completed	hyperalenia		24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of
g			25. Was case referred to medical	Of Place of Part	performe		2 N 0
5	Attending Physician: The ir death. ector: After this certificate ha ector; After this by the funeral director, page	o Be	examiner? Hospital: 1 Inpatient 2 ER/Outpatie	Other:	h <i>(Check only one)</i>	ce 6 □Other (Specil	
Ö	g Phy er this eral c	-	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how		<i>y</i> /
0	ath. rr: Aft	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division or	r Atte er de: irecto	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office :	28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
	oltal o urs aff ral D						
	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Medical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, deat (Check only one) 2				
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month,	Day, Year)
			Ind. I Do ED Physician	H006351	9 1	1/27/2	
			30. Name and and ss of person who completed cause of death (Item 23a) (Type,	Print) H006351		1 1	
			Jereny D Ticke 25,000 Point	outers Rd (conced	hom, MD	20650	
	Sta Registr		31. Date filed (Morkin, Day, Year) 32. Registrar's Signature		•		

2007 1420

		- For State Certificate of Death Reg. No.									Reg. No.			
Physicia	_	Decedent's Name (First, Middle,Last) Date of Death Month Day Yell The Company of the												3. Time of Death
ledical Exami		Robert Ridgway	Roden	berg II	Ι						April 19, 2	2007		1828 hrs
		4a. Facility Name (if not instituti	on, give stree	t and number)		41	. City, T	own, or Lo	cation of	Death		4c. County of	f Death	
		Frederick Memorial H	lospital				Frede	rick				Frederic	K	
=		5. Social Security Number	6. Sex	7 Age (In yrs. last bir	thday)	If Unde	r 1 Year	If Under	24Hrs.	8. Date of Bi	irth (MM/DD/YYYY	9. Bir	thplace (State or
Funeral Director		231-31-0772				anday,	Months	_	Hours	Min.		,	Foreig	Washington,
Director	ı	231-31-0772	1 X M 2	F	38	Yrs.				,	03/05	/1969	Co	untry) D.C.
		Usual Residence of Decedent												
any		10a. State 10b. County		11	c. City, Town	or Locatio	n							10d. Inside City Limits
* & O	_	Maryland Fre	derick		Frede	rick								1 X Yes 2 No
ff ff	윉	10e. Street and Number					10f. Zip	Code				10g. Citizen of Wh	at Cou	ntry?
Ma Ma	Director	138 E. 5th Str	oot			l		701			- 1	United S		
th the Maryland 23a or 28a-f sho														
ı wit ms 2	era	11. Marital Status		Vas Decedent E	ver in U.S.			nt of Hispa y Cuban, I			cify Yes or N	o- 14. Race White		ican Indian, Black,
deatl r ite	Fun	1 X Never Married 2	Married 1		No		o, op oo	,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		, , , , ,			
ifter	by	3 Widowed 4 D	vorced If Yes,	Give Year		11	Yes 2	XX No	specify:			Specify:	Wh	ite
urs a		15. Decedent's Education (Sp			eted) 16a.	Decedent'						16b. Kind of Bu	siness/	Industry
2 bc	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Coult a secondary (0-12) Coult a secondary (0-12)												
36 hin 3	힏	10 Subcontractor Cons									Const	ruc	tion	
-00 J wit gien ther	등	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden									Maiden Surname)		
1, 18 H	Be C	Robert R. Rodenberg, Jr. Julia Littl								ttle				
21215-0036 uld be filed within 72 hou Mental Hygiene. marked other than "nati	0.0										imber City or Tow	n State	Zin Code)	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once.	ř	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Numb 19b. Mailing Address (Street and Number or Rural Route Numb 19b. Mailing Address (Street and Number or Rural Route Numb 19b. Mailing Address (Street and Number or Rural Route Numb 19b. Mailing Address (Street and Number or Rural Route Numb 19b. Mailing Address (Street and Number or Rural Route Numb											5, Zip 6646)	
MD and 2 sho alth and m 27 is			g / Au	.11 C							Date	20c. Location -		Town State
Files I		20a. Method of Disposition 1 Burial 2 X Crematic	n 2 Do	movel from State	20b. Place crema	of Dispositions of Other					1 25,	20c. Location -	· City or	Town, State
nt of				moval irom State	Resth	23721	Crai	nator		-	.007	Freder	ick.	Maryland
Baltimore, permit. Pages I ar Department of Hee Important: If the		4 Donation 5 Other 21. Signatur - Ineral Service	e Livensee		Kesti									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'injury or other traumatic event, the Medical				puritir 1								es, Skko		
		220 Part I Enter the dispass	or complication	as that caused th	e death Don	ot enter th	OI C	of dying s	LIII I	rdiac or r	espiratory a	Frederic	art .	Approximate Interval
Physician /Medical		23a. Part I. Enter the disease, failure. List only one caus	e on each line).	e death. Do n	iot criter tri	e mode c	or dyning, o	0011 03 00	10100011	copilatory a	11000, 311000, 01 110		Between Onset and
rwiedical		Immediate Cause (Final diseas		rcotic (m										Death
taiiiici		or condition resulting in death)	Due to	(or as a conseq	uence of):									
		Sequentially list conditions,	b											ļ
	힐	if any, leading to immediate cause. Enter Underlying Caus		(or as a conseq	uence of):									
	Examiner	(Disease or injury that initiated	C	(or as a conseq	uanao of):	_						·		
ed sit	اێا	events resulting in death) Las		(or as a conseq	uence or).									
760, icate be executed physician and the burial - transit	اجا	77	d											
O. Box 68760, that the death certificate be exended by the attending physician a detached for use as the burial -	n/Medical	X UNPENDED		23a,27,28	-f,perM	E,g867	,5/3/	07 TT						
8760, tificate bing physic as the bun	Ne Ne	IF FEMALE:	230	. If yes, outcome	of pregnancy	/						23d. Date of		
68 ertifi ding e as t	an	23b. Was decedent pregnant in past 12 months?	tile 1			2 Fet	al death	3	Ectopic	pregnan	су	Month		Day Year
Box 68 le death cert the attendir ted for use a	Physicia	1 Yes 2 No 9 U	nknown 4	Pregnant at ti	ne or death	5 Oth	er (Spe	cify)						
e der	h		a	Unknown							0.0			
P.O. es that the	γP	Part II. Other significant cond	itions contr	ibuting to death	out not resulting	ng in the u	nderlying	cause giv	ven in Pa	rt I.				the cause of death?
res the signe	Completed by										1 Y	es 2 No 3	Pro	bably 4 🗹 Unknown
of Vital Records, P ng Physician: The law requires t ther this certificate has been sign meral director, page 2 should be o	ete										24a. Wa			utopsy findings available
law r has t	힐) 											death?	completion of cause of
Rec The cate page	팃										1 ✔ Yes	2 No 1	✓ Y	es 2 No
of Vital Rec ling Physician: The After this certificate funeral director, page	Be (25. Was case referred to medi-						26.Place		Check or	nly one)			
Vita ysici his o direa	0	examiner? 1 ✓ Yes 2 No	Hospita	al: 1 Inpatien	2 🗸 ER/0	Outpatient	3 📗 🗅	OA C	Other4	Nursing	Home 5	Residence 6	Othe	er:
Of Ing Ph		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occu									e how injury occur	red		
ndin th.	<u>.</u> 5	Natural 5 Pending Find 4/19/2007 Find 6:00 pm 1 Ves 2 X No unk.												
isior Attend r death ector: by the	cat	2 Accident Inv	estigation	28e. Place of Inju				office hu	ilding et			(Street and Numb	er or R	ural Route Number, City
Division pital or Attendit ours after death. eral Director: A	≒		uid not be	- ·	ouse	idini, on oc	1, 100101	,		1	20 Town,	State) 5th St. F	bood o	and als MD
the Hospital hin 24 hours the Funeral	Certification:	4 Homicide									_			
e Horiza Horiza Horiza e Fuit		29a. Certifier (Check only 1 Certifying	Physician: T	o the best of my	knowledge, de	eath occuri	ed at the	time, dat	e and pla	ice, and d	lue to the ca	use(s) and manne	r as sta	ted.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Funeral Divector After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 ✓ Medical Ex	aminer: On th and r	ne basis of exam manner stated.	nation and/or	investigati	on, in my	opinion,	ueath oc	curred at	uie ume, dat	te and place, and o		
F & F S	ž	29b. Signature and title of certi					29	c. License	number			29d. Date sign	ed (Mo	onth, Day, Year)
		O.C.M.E. April 20, 2									007			
		30. Name and address of pers	on who comple	ated cause of do	ath (Item 22a)									***
		· ·		eted cause of de edical Exami		Penn S	treet F	Baltimo	re. MD	21201				
						3,,,, 0			-,					
	tate	o i. Date illed (MonNhDVBV, Yoga	Date filed (Month Poex, Year) 7 2007 32. Figistrar's Signature											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death Day Physician Month Year ames DOINSON April 2007 /Medical 4b. City, Town, or Location of Death Facility Name (II not institution, give street and number, 4c, County of Death Examiner solisbure Wicamica eninsula 8. Date of Birth (Month, Day, Year) egiona If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 1 M 2 □ F Yrs. Director Mary Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits YYes 2 No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 91 12. Was Decedent Ever in U.S. Armed Forces? 1 Dives 2 No If Yes, Give Year or Dates: MAY 20, 1954 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BOGRD Elementary/Şeeondary (0-12) College (1-4or 5+) Driver Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be 6011 <0b1 NSON ဥ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ShanNow LWITE Delmar, DE Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility BENNIE SMITH Signature of Funeral Service Licensee sabella Salisbury FUNEral Home md 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) namomhere Physician stra centera /Medical Due to (or as a consequence of): **Examiner** Levkennie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 1 Yes 3 Probably 4 Unknown 24a. Was an autopsy performed?
1□ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Medical Certification: 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident hours after death uneral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) No thin 24 hours after on To the Funeral Direc 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

DHMH 17 Rev 1/2001

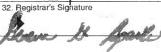
State Registrar

Year)

Rma

29b. Signature and title of

31. Date filed (Month, Day,



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

Salisburg

61822

SIVAKUMBR RAMAN,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** SIMMS Joseph 22:12 April 21 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bultimore If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 07/10/1937 9. Birthplace (State or Foreign **Funeral** Davs Hours 1 X M 2 □ F Mary land Director 220-36-7920 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 □ Yes 2 X No Director Maryland Howard Columbia 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 8778 Tamar Drive 21045 United States items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examiner. Once. Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Ş 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert Lane Martha Simms 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarissa Booze/Sister 214 Pindell Avenue, Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Lakemont Memorial Gardens 04/28/2007 Davidsonville, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatury WWWIO 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) days **Physician** Pheumonia /Medical Due to (or as a consequence of): **Examiner** Encephalopathy Moxic- [schemic Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760分 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? death? 1X Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 인 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Matural 2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jesse Kim, Medical April 21, 2007 Doctor RES-000

Registrar
DHMH 17 Rev 1/2001

State

Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hopkins

Registrar's Signature

Kim, The Johns

31. Date filed (Month, Day, Year)

MAY 02

07-03009 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Derwin G. Scott 1-For State Registrar Amend#19a.PerFHPGC4-27-07cm Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 19, 2007 Year 1417 hrs **Medical Examiner** DERWIN G. SCOTT 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Prince George's 3415 Dodge Park Road #304 Hyattsville 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** oreign Months Days Director Country) ALABAMA 1 X M 2 F 577 06 9340 39 10/09/1967 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 1 X Yes 2 No LANDOVER PRINCE GEORGES 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3415 DODGE PARK ROAD #304 20785 UNITED STATES Pages 1 and 2 should be filed within 72 hours after death with 1 cent of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 X Never Married 2 X No Yes f Yes. Give Year Yes 2 X No specify: Widowed Divorced Specify: BLACK marked other than "natural", Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE 3 YRS. COOK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2121 Be BERNICE McCAIN DANIEL SCOTT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) S ROSA ROBINSON / MOTHER Aunt FORT WASHINGTON, MD 20744 9803 GLEN WAY 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 WASHINGTON NATIONAL CEM. 4/28/07 SUITLAND, MD Donation 5 Other Specify 21. Si nature of Superal Service Licensee $^{22}.$ Name and Address of Facility MARSHALL'S FUNERAL HOME OF MARYLAND, INC. MD 20746 4308 SUITLAND ROAD SUITLAND, Approximate Interval I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and ire. List only one cause on each line /Medical Cardiac arrhythmia Imme te Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Dilated cardiomegaly with left ventricular hypertrophy Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last certificate be executed and Physician/Medical sician a X UNPENDED #23a-5,27,perME,g867,5/3/07TT Box 68760, attending phys for use as the bu 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) requires that the death 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö ş 1 Yes 2 No 3 Probably 4 ✔ Unknown Δ. Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has death? ✓ Yes 2 No 1 🗸 Yes certificate 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical of Vital Be examiner? Hospital: Other₄ Nursing Home 5 Residence 6 Other: Scene Inpatient ER/Outpatient 3 this 1 V Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification 1 X Natural Division Yes 2 Pending death. Director: 2 Accident Investigation

Death

Year

2 Nο

28f. Location (Street and Number or Rural Route Number, City

April 20, 2007

29d. Date signed (Month, Day, Year)

or Town, State)

24 hours after

State Registrar

Carol Allan, MD

Suicide

29b. Signature and title of certifier

29a. Certifier 1

Could not be

30. Name and address of person who completed cause of death (Item 23a)

(Specify)

and manner stated

Assistant Medical Examiner

determined

3

Medical

To the

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

			For	Type or Pri	aryland / [Оера	rtment of I	Health and			•	enny	110	0.0
			= State Registrar			Cer	tificate of	Death		Reg. N	o. <u> </u>	1_	146	US
	Physici	an	1. Decedent's Name (First, Middle, Las						2. Date of De Month April 1	ath D	ay Yea	r	3. Time of Dea	
	/Medic	_	David S. Spark										1:12	a. ^M
	Examin	er	4a. Facility Name (If not institution, give			İ		or Location of Deat	h	4	c. County of De			
	S. Albert		Montgomery Hosp			<i>(</i> - 1, 1)	_	ckville	I n D-t(Bi-		Mont			
-₹K	Funeral		5. Social Security Number 6. S	ex 1☑M 2 ☐ F	e (In yrs. last bir	rnaay) Yrs.	Months Days		(Month, Da	in ay, Yea	9. 1	Country		
	Director		568-05-0518 Usual Residence of Decedent		84				Dec. 8,	19	22 Pe	nns	ylvani	a
	land t		10a. State 10b. County		10c. City, Town	n or Lo	cation					10d	. Inside City L	imits
	Mary f sho ied a	ō	Manual Manta	070.7517	Pog	kvi	110						1 ☐ Yes 🍇	□No
	the 28a	Director	Maryland Montg 10e. Street and Number	Omery	NOC	IZ V T	10f. Zip Code			10g. C	itizen of What	Country	1?	
	ywith 3a or		10500 Rockville	Pike. #1	309		2	0852			USA			
	death ms 2:	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. \		Hispanic Origin? (Span, Mexican, Pue	Specify Yes or No)-	14. Race - A			
10	r Ite	F	1 Never Married 2 Married	Armed Forces?					to Rican, etc.)		Black, W			
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at	by	3 🛣 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 □ Yes 2 X No	Specify:			Specify: Wh	nite		
9	72 ho natur lical	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a.	Deced (Give	dent's Usual Occu	pation	rkina	16b.	Kind of Busine	ss/Indu	stry	
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	er th	Ş		5+			Professo	T .			iversit	у о	± MD	
nd	tal Hy	Be	17. Father's Name (First, Middle, Last,						me (First, Middle	, Maide	n Surname)			
yla	ould Men arke	To Be	Richard F. Spark					Grace D						
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23a or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Elizabeth Anne S	**	I		-	tand Number or R venue, Un		-				
	and lealth m 27	(9		parks/ bau			sition (Name of				Location - City			
Baltimore,	permit, Pages 1 an Department of Heal Important: If item 2 any Injury or other once.	- 8	20a. Method of Disposition 1 ☐ Burial 2 € Cremation 3 ☐		cemete	ry, crer	matory or other pla	1 "	il 17,					
Ę	tmen tant: tant:		4 □ Donation 5 □ Other (Specif		Metrop		tan Crem		007		xandria		ırgını	a
3a	permit. Departr Importa any Inju		21. Signature of Funeral Service Lice	nsee		24	Francis	ess of Facility J. Colli	ns Funer	al.	Home Ir	ıc:	•••	200
	H H H H H		23a. Part 1. Enter the disease, or com	plications that source	of the death Do	not ont		versity B			Iver Sp	_		
	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Pulmon	ne. arv Fibr a consequence	osi						l	Approximate nterval Between Drawn and Dea	en .th
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause Enter Underlyin. Cause (Disease or injury	Due to (or as	a consequence	of):						İ		
,09	eath certificate be executed attending physician and for use as the burial-transit		that initiated events resulting in death) Last	Due to (or as	a consequence	of):								
687	certificate be iding physicia ise as the bur	edic												
P.O. Box	the death cert	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e pf pregnancy 2 Fetal death at time of death		Ectopic pregnan Other (specify)	су			23d. Date of Month		ay Yea	.г
	w requires that the debeen signed by the should be detached	5	Part II. Other significant conditions	contributing to death I	out not resulting i	n the u	nderlying cause g	iven in Part I.			use contribut			
Ö	requ been shoul	ete			·				24a. Was	an.	24h Word	autons	ey findings ava	ilahle
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Z:	Physician: this certific ral director,	B	25. Was case referred to medical examiner?	Hospital:				U	eath (Check only					
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L	Jing After fune	<u>0</u>	1 Natural 5 Pending	(Month, D		Injury	W	ork? □Yes 2□No	200. 200020		,,			
Division or Vital Records,	or Attending after death. Director: After In by the fune	Certification:	2 Accident Investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of in	jury - At home, fa tc. (Specify)	arm, str	reet, factory, office		28f. Location City or To		and Number of ate)	Rural	Route Number	r,
1	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Co		hysician: To the besi miner: On the basis and manner s	of examination ar									
	To th within Го th	Me	29b. Signature and title of certifier	_ `	`			nse number		-	Date signed (M			
			Deynthia m	Delles	ecen		HOU	58032		a	pril 1	7,2	007	
	D		30. Name and address of person who			(Type,	Print)							
			Cynthia Williams,					Road, Roc	kville,	MD	20855			
	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 1 8 20	Regist	trar's Signature	Con	WE							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 10:55AM M Theresa J. Smolinski April 2007 16, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Village Health Care Center Montogmery Village Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🗙 F Yrs Director 80 June 26, 1926 157**-**14**-**8353 New Jersey Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director Glenwood Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 0 or items 23a 14585 MacClintock Drive 21738 by Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3₺ Widowed 4 Divorced 'natural", Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Gift Shop Entrepreneur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of မ Anthony Szeluga Sophie Rozalska 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 14585 MacClintock Drive, Glenwood, MD 21738 <u> Jacinta Mary Everett (Daughter)</u> 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or of once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 4/21/2007 N. Arlington, NJ 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Funeral Service License 23a. Cart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine spital or Attending Physician: The law requires that the death certificate be executed ours after death.

In the continuation of the continuation of the attending physician and filled in by the trust director, page 2 should be detached for use as the burla-transit Diabetes Mellitus that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 K No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Arthritis, Sacral Decubitus 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2X No 24a. Was an autopsy perform 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 1 No Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a
To the Funeral I 29a, Certifier 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR

Vinu Ganti, M.D. 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 8 2007

19529 Doctors Drive, Germantwon, MD 20874

29c. License number

D41162

29d. Date signed (Month, Day, Year)

April 17, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra MEND#24a, 24bperMD4/19/07, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 11:05 am Mary Ellen Sayre April 14, 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Renaissance Gardens-Riderwood Nursing Home Silver Spring Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 😿 F 046-20-3314 86 Director September 2,1920 Missouri Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

Hydrer than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 1 ☐ Yes 2x No Director Silver Spring **Maryland** Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 U.S.A. Funeral 3124 Gracefield Road, #T21 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☒ No Specify þ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If frem 27 is marked other the any Injury or other trainmant. ortant: If item 27 is marked other tha Injury or other traumatic event, the Injury or other traumatic event, Writer-Editor Federal Reserve 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mark Silverstone Frances Louise Assacs ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Phillip Sayre - Husband 3124 Gracefield Road, #T21, Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buria 2 Cremation 3 ☐Repaçval from State 5 Other (Specify) 4 Domation Ft. Lincoln Crematory 4/19/2007 Brentwood, Maryland 21. Signa ure of uner Service Liber(see 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Physician Alzheimer's Disease /Medical Due to (or as a consequence of) Examiner Adult Failure to Thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Depression the attending physician and burial-trar Due to (or as a consequence of): Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗷 No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 INo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an certificate has autopsy performed? 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 ☐ Yes 2 🔀 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier,

Division or Vital Records, P.O. Box 68760, the 養品

Saltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) APR 18



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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D59524

April 16, 2007

			1 - For State Registrar	State of Ma	arylan	d / Depa <i>Cei</i>	artmen <i>tificat</i>	t of H e of L	ealth a Death	nd M		giene Reg. No.	007	William () and	4212
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	To the Hospital or Attending Physician: The law within 24 buous after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2.	edical C	29a. Certifier 1 Certifying Pl	hysician: To the best of miner: On the basis of	examinati	vledge, death ion and/or inv	occurred a	at the time in my op	e, date and inion, death	place, ar	d due to the o	cause(s) and	d manner a	s stated.	cause(s)
	o the vithin 2 o the omple	Med	29b. Signature and title of certifier	and manner sta	ued.			License				29d. Date s			
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			30. Name and address of person who	completed cause of de	eath (Item	23a) (Type, F	Print)	احم ا				71	010		
3	4-10		William B. Kerns		11 Je	effers	on B1	vd.	Smit	hsbu	rg, MD	218	373		
	Sta Registr		31. Date filed (Month, Day, Year) APR 19 2	2007 32. Registra	ar's Signati	d. So	ele								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** THOMAS EDWARD SUROWICZ 2007 April 13, 12:10a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3850 Enfield Chase Court, #213 Bowie Prince George's If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1XM 2□ F Director 199-16-1228 80 07-05-1926 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 X Yes 2 ☐ No Director Maryland Prince George's Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3850 Enfield Chase Court, #213 20716 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1∑)Yes 2□ No 1944-If Yes, Give Year or Dates: 1946 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Navy <u>Program Analyst</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Surowicz George Josephine Woloska ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Surowicz - Wife 3850 Enfield Chase Court, #213, Bowie, MD 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. Q4-23-2007 Crownsville, Maryland 21. Signal Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bladder Cancer Holvanced Physician TONY YES /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Arterv 2 No 3 Probably 4 Unknown 1 Tes Completed Hyperlipidemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Bitascicular 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🗖 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

Division or Vital Records, P.O. Box 68760, Vithin 24 hours after death.

To the Funeral Director: A in by

Medical State Registrar

29b. Signature and title of certifier

determined

29c. License number

D31001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) April 16, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stuart J. Turkewitz, MD 7500 Greenway Center Drive, #430, Greenbelt, MD 20770

31. Date filed (Month, Day, Year APR 1 8 2007

3 ☐ Suicide

29a. Certifier

4 | Homicide



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 20 9:40 A M Kathryn Stauffer Stauffer 2ďď7 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 28465 Point Lookout Road Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🖾 F Yrs. 3 213-71-1719 Director December 9, 2003 Maryland Usual Residence of Decedent death with the Maryland a or 28a-f show t be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 □Yes 2√ No Maryland **Funeral Director** St. Mary's Leonardtown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a 28465 Point Lookout Road 20650 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. White Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never Worked Child 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nathaniel Brubacher Stauffer Miriam Martin Stauffer 흔 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28465 Point Lookout Road Leonardtown, MD 20650 Nathaniel Brubacher Stauffer / Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 25 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loveville 20Ó7 Loveville, Maryland 4 Donation 5 Dother (Specify) Mennonite Cemetery 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardio remination disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** posiin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine sician and burial-transit The law requires that the death certificate be executed tiated events resulting in death) Last Due to (or as a consequence of Division or Vital Records, P.O. Box 68760, physician s the buria Physician/Medical Necnata جا as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Courdinated 1 | Yes 2 No 3 | Probably 4 | Unknown 1 swallow 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform 2 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident neral Director / 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I completely filled Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Registrar

Year) APR 2 3 2007

5

Amarpeast S. Dhillon.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

AMARPREET



and manner stated

WASHINGITON

29c. License number

DOO 28290

29d. Date signed (Month, Day, Year)

4.20 07

St. Leonardtown, Md, 20650.

		•	For State Registrar	State	of Maryla		artment of F rtificate of			giene 007	14215	
	Physici	1. Decedent's Name (First, Middle, Last) Sician Nina Gladine Smith								ith Day Yea		
	Physicia /Medic		Nina Glad	Apri			24, 2007	3:05 A M				
	Examin	er	4a. Facility Name (If not institution Dennett Road		4b. City, Town, or Location of Death Oakland Garrett			eath				
	Funeral		5. Social Security Number	6. Sex 7. Age (In yrs. last birthday)			If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h 9. F	irthplace (State or Foreign	
П	Director		220-32-4654	1□M 2∭[F	90	Yrs.	Months Days	Hours Min.	Jan. 29	9, 1917 We	st Virginia	
	DUE A		Usual Residence of Decedent 10a. State 10b. County		10c. 0	City, Town or Lo	cation				10d. Inside City Limits	
	f sho	Completed by Funeral Director	MD Garrett Oakland 1 □ Yes 2 No									
	1 the		10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?		
	u within 72 trous and usedit with the wayyand jene. Then "natural", or itema 23a or 28a-f show If a Medical Examinat must be notified at		807 Pysell Crosscut Road				21550			USA		
			11. Marital Status 1 ☐ Never Married 2 ☐ Marr	Armed F ied 1 ☐ Yes	2 📉 No		Was Decedent of H If Yes, specify Cuba		pecify Yes or No- p Rican, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc.	
215-0036			3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:			1 ☐ Yes 2 🎇 No Specify:				Specify:	White	
2	natu natu		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			(Give	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Busines	ss/Industry	
	within 72 ene. then "nei te Medic					me.				Home		
	es 1 and 2 should be tiled wold Heelth and Mental Hygier if item 27 is marked other the other traumatic event, II.	Be Co	17. Father's Name (First, Middle,	Last)					ne (First, Middle,	Maiden Sumame)		
Maryland		ToB	William He	nry I	Hartman			Alice	Heste	er Ril	ey	
ar)			19a. Informant's Name/Relations							r, City or Town, State		
			Bernadine D. T	asker/ Da			Truesdale	e Road, O	akland,	Maryland 20c. Location - City	21550	
Ö	Pages nent of h int: If its iny or of		1 █ Burial 2 ☐ Cremation		State	cemetery, crei	matory or other place c Cemeter				, Maryland	
altimore,	permit. Pages Depertment of I Important: If its eny injury or o		4 Donation 5 Other (S		וען	7	2. Name and Addre			S. Second		
ñ	Ped Ped Ped Ped Ped Ped Ped Ped Ped Ped		> Beally, of	May		S	tewart F	ineral Ho		kland, MD	21550	
	Cate be executed /Medical Examiner the purial-transit the purial-transit		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									
			Immediate Cause (Final disease or condition Ovarian Cancer 5 Years									
			resulting in death)	Due to	o (or as a cons	equence of):						
		d by Physician/Medical Examiner	Sequentially list conditions, 1 any, leading to inministrate cause. Enter Underlying									
			cause. Enter Underlying Cause (Disease or injury that initiated events c.									
o,			resulting in death) Last	Due to	Due to (or as a consequence of):							
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0.	at the de f by the e etached i		9 Unknown									
Division of Vital Records,	The law requires that the tie has been signed by th page 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 100 3 Probably 4 Unknown									
S	s been s been	lete	Hypertension						24a. Was			
E E	: The law cate has I page 2 s	Certification: To Be Completed							perfo	autopsy prior to completion of cause of performed? death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No		
ıta	ilcian: Th certificate rector, pag		25. Was case referred to medical examiner?									
<u> </u>	Hospital or Attending Phys 4 hours ater death. Funerel Director: After this ely filled in by the funeral di		1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								рөсіfу)	
uo .			1 Natural 5 Pendir	28b. Time o Injury	28d. Describe how injury occurred Work? M 1 Yes 2 No							
/ISI		flca	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,							8f. Location (Street and Number or Rural Route Number,		
		Cert	4 Homicide building, etc. (Specify) City or Town, State)									
		Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To the I within 2 To the I complet		29b. Signature and title of certifie				29c. Licens	e number		29d. Date signed (Mo	onth, Day, Year)	
)) +	1/1				D15333		4/25/0	7	
		6	30. Name and address of person who impleted cause of death (Item 23a) (Type, Print)									
Dr. Thomas Johnson, MD 311 N. Fourth St., Oakland, Maryland 21550 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature												
	Registr			5 2007	Page 1	Ac	books.					

State of Maryland / Department of Health and Mental Hygiene [For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6:15 P.M April 23 2007 William E. Stewart, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Garrett Oakland Dennett Road Manor Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 21 9. Birthplace (State or Foreign Country) Pennsylvania 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral X**□M 2□ F Hours Months Days 1952 Director 187-44-0391 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a State 10h Counts or 28a-f ehow Hygiene. stherthen "netural", or Iteme 23e or 28e-f ehow ent, the Mactical Examiner must be notified at 1 ☐ Yes 2√ No McHenry MD Garrett Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21541 United States 1286 Limpopo Lane Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 Yes 2 No Maryland 21215-0036 Specify: Specify: þ Year or Dates: 3 ☐ Widowed 4 🕅 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Construction laborer 12 Peges 1 and 2 should be filed v itment of Health and Mental Hygie rtant: If Item 27 le marked other t njury or other treumatic event, ib other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Heibert William E. Stewart, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1286 Limpopo Lane, McHenry, MD 21541 Mrs. Margaret Stewart, Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny injury or once. Cumberland, MD Cumberland Crematory 4/25/07 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. Second Street, Oakland, MD 21550 Katherin Dureter 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) year Metastatic carcinoma of tongue **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) sete has been signed by the page 2 should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, chronic obstructive pulmonary disease 1. Tes 2 □ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No alcoholic hepatitis 1 Tes 2 No 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To this After this funeral of 27. Manne eath 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation Natural efter death. I Director: Aft d in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 - Homicide within 24 hours e To the Funerel C Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D15333 30. Name and address of per on what completed cause of death (Item 23a) (Type, Print) Dr. Thomas G. Johnson, 311 North 4th Street, Oakland, MD 21550 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 5 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** APRIL 26, 2007 ar :50PM THOMAS LEE NELSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES HUGHESVILLE 6560 HARVEST RIDGE ROAD 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Birthplace (State or Foreign Country) Days M 2□F Hours Min. 217-70-5646 49 NOV.5,1957 Director MD. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified of once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD. CHARLES Director HUGHESVILLE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Be Completed by Funeral 6560 HARVEST RIDGE ROAD 20637 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry TBN ASSOC. Elementary/Secondary (0-12) College (1-4or 5+) **ESTIMATOR** INSULATION CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FRANK N. THOMAS ပ္ VIRGINIA L. THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6560 HARVEST RIDGE RD. HUGHESVILLE, MD. Date 20c. Location - City or Town, Selection - City or T BARBARA THOMAS-SPOUSE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State FT.LINCOLN CEMETERY 5-1-07 | BRENTWOOD, MD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee MOO479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 repose 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin-Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner By or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, physician by Physician/Medical the IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day signed by the at the detached for 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2210 this certificate 1 | Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: 1 Yes 2 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainer as stated.

and manner stated. (Check only one) 29b. Signature and title of cortiner 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 10 120 70 old D. 20609 3 Registrar's Signature

Registrar

State

31. Date filed (Month, Day, Year)

MAY 02

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Τ. Harvel Turner 11:07 2007 April 15, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Months Min. 1 □ M 2 € F Director Texas Dec. 31, 1912 579-48-0996 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Kensington 10g. Citizen of What Country? 10e. Street and Number 3616 Littledale Drive 20895 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No Specify: þ SpeciWhite 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Una Mary Broussard James Vernon Taylor ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Suzanne Street/Daughter 112 Riverside Terrace, Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Metropolitan Crematory April 17 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria, Virginia 4 Donation 5 DOther (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Lice 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) and drac **Physician** /Medical Due to (or as a consequence of) Examiner the sosclesofic Sequenticity has concluded if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ypestension The law requires that the death certificate be executed Due to (or as a cons equence of): ementsa. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate 1□ Yes 2 No Hospital or Attending Physician: 24 hours after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 No 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After Natural (Month, Day Year) Injury 5 ☐ Pending investigation М 1 ∏Yes 2 ∏No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide riffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Compared to the cause of the cau 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title D53691. 5)emony Blud, 30. Name and add s of pers in who completed cause of death (Item 29a) (Type, Print)

DHMH 17 Rev 1/2001

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Registrar

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Baltimore, Maryland 21215-0036

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Box 68760,

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Vital Records.

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 12:14 ^{A M} April Bernadette Tran Van Kha 14, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda nder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6614 Wilson Lane Montgomery 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Yrs. July 24, 1943 Director 220-31-2387 63 FRANCE Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1X Yes 2 No Director Md. Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6614 Wilson Lane FRANCE 20817 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗓 No þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be filitiment of Health and Mental H tant: If Item 27 is marked oth Jury or other traumatic even Be ပ Andre Mercier Genevieve Saint-Denis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) <u>6614 Wilson Lane, Bethesda, Maryland 20817</u> <u>Henri Tran Van Kha / Husband</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 23. permit. Pages Department of Important: If It any Injury or or 1 ₭ Burial 2 Cremation 3 Removal from State Valbonne, France 4 Donation 5 Other (Specify) Cimetiere de Valbonne 2007 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licunsee 2222 Wisconsin Ave. N.W. Washington, D.C.20007 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Pancreatic Cancer 3 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) physician Physician/Medical as the t attending i 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 🔀 No ed by the 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe certificate 2 No : After this certifications and all the thick 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 💹 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No death. after death Director: / 2 Accident 6 Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0033293 April 16, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick P. Smith M.D., 5454 Wisconsin Ave. #1300 Chevy Chase, Md. 20815 31. Date filed (Month, Day, Year) Registrar's Signature State

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Baltimore.

Records, P.O. Box 68760,

or Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** JOHNNY LEE TRUESDALE, Sr. \mathbf{A}^{M} 9:12 April 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring
If Under 1 Year | If Under 24 Hrs. Montgomery Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1☑M 2□F Months Days Hours Min. 60 Director 249-84-0664 May 22 1946 Flat Rock, SC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show iral", or Items 23a or 28a-f shov Examiner must be notified at Director 1 Yes 2 No Maryland Prince George's Seat Pleasant 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6718 Valley Park Road 20743 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 □ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) other than College (1-4or 5+) 12 Private Construction Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental ! J. W. Truesdale Willie Mae Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. Shirley Truesdale/Wife 6718 VAlley Park Road, Seat Pleasant, Maryland 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crematory 4/14/2007 4 ☐ Donation 5 ☐ Other (Specify) Alexandria VA 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licenses 5538 Marlboro Pike, Forestville, Maryland 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrhythmia /Medical Due to (or as a consequence of) **Examiner** Left Pneumonopathy Sequentially list conditions, if any, reducing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine The law requires that the death certificate be executed Lung Cancer attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy 1⊠ Yes 2□No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 🔼 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 No 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2.

To the I complet 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D59867 April 10, 2007

State

Dr. Lawrence J. Markovitz, 2101 Medical Park Drive, Silver Spring, Maryland 20902 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Marck BETTY ELAINE THOMPSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death County of Death Examiner (Emonia) If Under 24 Hrs. **Funeral** Hours 1 □ M 2 X F MARYLAND 214-32-0355 OCT. 1, 1932 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Completed by Funeral Director GRASONVILLE **OUEEN ANNE** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21638 38 GRASONVILLE TERRACE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify. Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 -0-18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be MARGUERITE BOYLES HARRY LANE FAULKNER ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24685 DUKES ROAD, GREENSBORO, MD 21639 DAWN THOMAS/ DAUGHTER more. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4-3-2007 CENTREVILLE, MD 21617 CHESTERFIELD CEMETERY 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facili FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician re spirater ain disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, county to involve cause. Enter Underlying Cause (Disease or injury Examiner requires that the death certificate be executed burial-transi ated events resulting in death) Last attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) led by the a o 9 Unknown ₫. signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has autopsy The perform certificate or Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day 28h Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

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egistrar's Signature

Decident Name (First Addition Last) James Roberts Taylor James Roberts Roberts Taylor James Roberts Roberts Taylor James Roberts Roberts Taylor James Roberts Roberts Roberts Taylor James Roberts Rob				. For		Maryland	d / Depa	artment	of H	ealth a		ental Hygi	iene	10.7	11000	
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25. Was case referred to medical examiner? Yes 25 No No No No No No No N	ds.	puires n sign	q p	Diabetes								1 □ Ye	s 2020	o 3∏Prob	ably 4 Unknown	
25. Was case referred to medical examiner? Yes 25 No No No No No No No N	000	~ Q 70	ojete	Atherosclerosis									n 24	b. Were autop	psy findings available	
25. Was case referred to medical examiner? Yes 25 No No No No No No No N	Re	The la	E	1+TN			autops perform					perform	ned?	death?		
28a. Date of Injury Work? M 1 Yes 2 No 28b. Injury at Work? M 1 Yes 2 No 28c. Injury at Work? Mork? M	ita	artifica ctor.		avaminar?							of Death	(Check only on	θ)			
27. Manner of Death 1	Ž	hysic his ca	은	1 ☐ Yes 2 ≧ No	1 🗆 Iub				/A	4 🗆 NU					o Haspre	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	n C	ling P	ion:	1 Aatural 5 ☐ Pending	28a. Date of (Month,							280. Describe no	w injury oc	curred		
4 Homicide 4 Homicide 4 Homicide 5 building, etc. (Specify) 4 Homicide 5 building, etc. (Specify) 5 building, etc. (Specify) 6 building, etc. (Specify) 7 building, etc. (Specify) 7 building, etc. (Specify) 7 building, etc. (Specify) 7 building, etc. (Specify) 7 building, etc. (Specify) 8 building, etc. (Specify) 8 building, etc. (Specify) 8 building, etc. (Specify) 9 building	isi	death ctor: / the	icat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 28e Place of Injury - At home, farm, street, factory, office 28f. Location (Street and No.								reet and Nu	umber or Rura	l Route Number.		
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	Ο̈́	after Dira Jin by	ertii	4 Homicide determined	building	, etc. (Specify										
and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated to the cause (s) and manner as stated t									ated,						
250. Signature and title of certains 1 4/12/07	1745818 4/15/a/															
100									-w, 1841)							
h and Name and address of passes who completed equipe of death (from 32a) (Tuna Brint)																
-2- 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) (RATSurguyne M 555 Cynhurod D. EASON MD 2/60)																
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar APR 1 6 2007					4	istrar's Signat	ture	- 40								

			1 - For State Registrar	State	of Maryla	and / Depa <i>Cei</i>	artment of F rtificate of	lealth and <i>Death</i>	d Mental Hy	/giene Reg. No.	007	14223					
	Discontinu		1. Decedent's Name (First, Middl	e, Last)					2. Date of D Month	eath Day	Year	3. Time of Death					
	Physici /Medic		BELLE S. V.	IERS					April		2007	12:05A M					
·	Examin	_	4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town, o	r Location of D		4c. Co	ounty of Death	1					
			1811 Glen Cove		,		Darli:				Harfo						
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ဩ F		rs. last birthday)	If Under 1 Year Months Days		#rs. 8. Date of B #in. (Month, D 4/21/	irth ay, Year)	9. Birth	nplace (State or Foreign untry)					
	Director		245-42-9249 Usual Residence of Decedent	-X	9	7 Yrs.			4/21/.	1910	Nor	th Carolina					
	land		10a. State 10b. County		10c.	City, Town or Lo	cation					10d. Inside City Limits					
	Mary 	ō	MD Har	Ford		Darling	rton					1 ☐ Yes 2 No					
	28a	Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Co	untry?					
	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f ehow the Maidical Examiner must be mullied at		1811 Glen Cove	Road			2103	4		1	USA						
	death ms 2	Funeral	11. Marital Status	12. Was De	cedent Ever i	n U.S. 13.	Was Decedent of H	lispanic Origin?	? (Specify Yes or N	0- 14.	Race - Amer						
9	after or its		1 ☐ Never Married 2 ☐ Mar		2 ₩ No		1 □ Yes 21√2 No	Specify:	uento nican, etc.)		Black, White						
ဋ	iours irel',	Completed by	3 Widowed 4 □ Divorced	Year or				эреспу.		3,	Decity.	wiii te					
7	72 h	ete	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry														
12	han han	μ	Elementary/Secondary (0-12)	College	(1-4or 5+)			<i>3)</i>			Oran Li	omo					
22	Hygie Hygie ther t		17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alice Darnell														
ano	d be i	m															
Maryland 21215-0036	shouls mark matt	ဥ	17. Father's Name (First, Middle, Last) James Sheets 19a. Informant's Name/Relationship (Type, Print) Glenda Dillard/Daughter 181 Glen Cove Road, Darlington, MD 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City														
	nd 2		Glenda Dillar	James Sheets Alice Darnell a. Informant's Name/Relationship (Type, Print) Glenda Dillard/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1811 Glen Cove Road, Darlington, MD 21034 1. Method of Disposition 20b. Place of Disposition (Name of Company													
ē,	s 1 a f Hea ltem othe		Homemaker Homemaker Own Home														
Ë	Pages nent of I		Homemaker Homemaker Homemaker Gwn Home														
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deporantent of Health and Mental Hygiene. Importants if Item 27 is marked other than "naturel, or items 23s or 28s-f show any injury or other traumatic event, the Madical Extension must be notified at ance.		21. Sign ware Funeral Service	Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)													
	20244		James Sheets Alice Darnell James Sheets Alice Darnell James Sheets Alice Darnell James Sheets Alice Darnell James Sheets James Sheets Alice Darnell James Sheets James Sheet														
			Glenda Dillard/Daughter 1811 Glen Cove Road, Darlington, MD 21034 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 1X Burial 2 Cremation 5 Other (Specify) Peak Creek Cemetery 4/28/2007 Laurel Springs, NC 21. Sign are Funeral Service Licensee 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314 234 Part. Ebter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Approximate Interval Between Onset and Death Cardio myopathy Approximate Interval Between Onset and Death Cardio myopathy														
	Physician /Medical		Harkins Funeral Home, Inc., Delta, PA 17314 234 Parti. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Interval Between														
П	Examiner	Immediate Cause (Final disease or condition Is chemic Cardionyopathy a															
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to													
de	uted d ansit	듄	ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):														
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8760,52	cate be executed physicien and the burial-transit	dical		d													
9	ng ph	Med	IF FEMALE:														
Вох	death certiff	an/I	23b. Was decedent pregnant in the past 12 months?		230	d. Date of deli	very Day Year										
E	e dea the at	Physician/Me	1 Yes 2 No	4□Preg 9□Unk	nant at time o nown	of death 5	Other (specify)				Mortui	Day real					
P.O.	that the death certificated by the attending to detached for use as		Part II. Other significant conditi	ons contributing to	death but not	resulting in the u	nderhing cause an	en in Part I	23a Did	tohacco use	contribute to	the cause of death?					
Division of Vital Records,	S C 0	d by	Periphera	1 Vas	cular	015	ease.	or in a divis	1			bably 4 Unknown					
Ö	w require been si should t	ete	4			-			-								
Rec	o	Completed							— 24a. Wa — auto per	opsy formed?	prior to c death?	topsy findings available completion of cause of					
ā		င်	25. Was case referred to medica						1□ Yes	2 10 No	1 🗆 Yes	2 No					
⋚	Physician: this certific ral director,	To Be	examiner?	Hospital:	Inpatient 2	2 ☐ ER/Outpatier	nt 3[] DOA Ott	00	Death (Check only	/	Other (Con-	14.1					
o o	9 Phy eral c		27. Manner of Death	28a. Date	of Injury	28b. Time o	28c. Injur	y at	28d. Describe			my)					
<u>0</u>	Attending ir death. ector: After by the fune	atlo	1 ☑Natural 5 ☐ Pendir 2 ☐ Accident investi	19	nth, Day Yea	r) Injury	M 1 🗆	Yes 2 □ No									
<u>\s</u>	r Atte	Certification;	3 Suicide 6 Could 4 Homicide determ	nined 200. Flat	e of Injury - A		eet, lactory, office			(Street and I	Number or Ru	ral Route Number,					
	tal or rs afte al Dir	Cer															
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifyii (Check only 2 Medical one)	ng Physician: To the Examinar: On the and ma	ne best of my basis of exam nner stated.	knowledge, deati nination and/or in	n occurred at the til vestigation, in my o	ne, date and pl pinion, death o	lace, and due to the occurred at the time	e cause(s) ar , date and pl	nd manner as lace, and due	stated, to the cause(s)					
	To the within 2 To the complet	Me	29b. Signature and title of certifie	or .			29c. Licens	e number		29d. Date s	signed (Month	n, Day, Year)					
)			· ///				1	350,	12	Apr	1/26	, 200/					
	n		30. Name and address of person	who completed car	use of death (Item 23a) (Type,	Print)	A	2.1	A:-	MI	2 10/16					
	3 Sta	to	31. Date filed (Month, Day, Year,	Lyar CH	Registrar's Si	3 /	vor/4	Tue.	. 1961	111/		to the cause(s) 1. Day, Year) 1. 2007 2. 1014					
T. S.	Registr		MAY 02	2007	Ales d	J. Mon	S. Sand										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month Year **Physician** APRII 18, 2007 8:11A.M Martha Hunter VAUGHN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Boonsboro If Under 1 Year | If Under 24 Hrs. Washington Reeders Memorial Home Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 □ M 2 🔽 F 88 March 27 1919 Maryland Director 217-12-1331 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notified at 1 ☐ Yes 2 ☐ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number ō must be NAME: NAWAIN ST215-0036 Baltimore, Maryland 21215-0036 <u>USA</u> or items 23a 21740 17504 Greenmeadow Lane Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. other traumatic event, the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2X No Specify ρ White 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Hospital 12 Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Thomas Hunter Shirley <u>Catherine Virginia Darrlington</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 138 Flowerwood Drive, Falling Waters, W. Va.

Disposition (Name of Date 20c. Location - City or Town, State Hunter Griffith - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hagerstown Crematory 4/19/07 Hagerstown, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CALDIAC MURYTUMING 1-2 HRS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner MYOCONCOLOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): The law requires that the death certificate be executed Allen burial-trai Division or Vital Records, P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient P this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural
2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 04656 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GHAZALA QADIR, 20311 LAPPANS ROAD, BOONSBORO, MARYLAND 21713 301-432-8470

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) APR 19

ORIGINAL

32. Registrar's Signature

		_1	For State of Mary	•	rtificate of I		Re	g. No.2007	14225	
Ph	ysicia		Decedent's Name (First, Middle, Last) SUSAN META		WHETZEL		2. Date of Death Month	Day Year	3. Time of Death	
	Medica amine	0.2	4a. Facility Name (If not institution, give street and number) WMHS-BRADDOCK CAMPUS			r Location of Death	04	4c. County of Dea		
Fun Dire	_		4□M 2₩ 5	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 29		thplace (State or Foreign ountry) lifornia	
yland	Ħ	-		c. City, Town or Lo	cation	. <u>-</u>			10d. Inside City Limits	
e Mar 8a-fsk	tified	Director	WV Mineral	Key					1 ☐ Yes 2X No	
with th	pe no	Dire	10e. Street and Number		10f. Zip Code	5726	10	g. Citizen of What C	,	
death ms 23	mus	Funeral	Rt. 2, Box 234-E 11. Marital Status 12. Was Decedent Ever Armed Forces?	r in U.S. 13.		0 / 20 lispanic Origin? (Spo an, Mexican, Puerto	ecify Yes or No-	14. Race - Am	erican Indian,	
Nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If frem 27 is marked other than "natural"; or items 23a or 28a-f show	Examine	by	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2X No		nican, etc.)	Specify:	hite	
15-0 72 h "natu	edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of work	ing	16b. Kind of Business	/Industry	
212 d within giene.	the M	ошо	Elementary/Secondary (0-12) College (1-4or 5+) 12 (GED)		memaker	- /		Own	Home	
Maryland 21 2 should be filed w and Mental Hygie 1s marked other t	event,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	,	,		
Maryland of 2 should be file th and Mental Hy 77 Is marked othe	natic e	၉ .	Earl Z. Smith 19a. Informant's Name/Relationship (Type. Print)	10h Mailir	og Address (Straat		id Martha	a Helm City or Town, State,	Zin Code)	
Mal nd 2 sl alth an 27 is r	r traur		Theodore A. Whetzel/Husband		. 2, Box		Keyser, N		zip oode)	
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 27	r othe			20b. Place of Dispo		ce)	Date 2	20c. Location - City of	Town, State	
timent tant: I	jury o		4 ☐ Donation 5 ☐ Other (Specify)	Potomac M			Pril 25 2007	Keyser,	WV	
Bal permit Depar	any In	ļ	21. Signature of Euperal Service Licensee		2. Name and Addre	ss of Facility Sn ain Street		eral Home r. WV 267	26	
	50	+	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ent					Approximate Interval Between	
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/Med Exam			resulting in death) Due to (or as a co	onsequence of):						
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in the contract of the contrac	ransit	Examiner	Cause (Disease or injury that initiated events c.							
68760, Egilicate be executed g physician and	s the burial-transit		resulting in death) Last Due to (or as a co	onsequence of):						
687 rtificate	as the	Medical	UE ESTANIS.							
Box death cert eatherdin	or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf properties the past 12 months?	Fetal death 3	Ectopic pregnancy	у		23d. Date of de Month	livery Day Year	
the de	ched f	iysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	e of death 5L	Other (specify) _					
Records, P.O The law requires that the te has been signed by th	should be detached for use a	by Ph	Part II. Other significant conditions contributing to death but no	ot resulting in the u	nderlying cause giv	ren in Part I.	23e. Did tob	acco use contribute	o the cause of death?	
ord; equire	d bluo	ted k					1 □ Ye	es 2 5 40 3 ☐ F	robabiy 4 □Unknown	
e law has be	2	Completed					24a. Was ai autops	v prior to	utopsy findings available completion of cause of	
	or, page		25. Was case referred to medical			26. Place of Deat	perform 1 Yes 2			
or Vita Physician:	-₩	To Be	examiner? 1 Yes 2 No Hospital: 1 npatient	2 ER/Outpatier	nt 3 DOA Oth	or.		ence 6 □Other (Sp	ecify)	
I g	nera		27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Ye	28b. Time o Injury	Wor		28d. Describe ho	w injury occurred		
Division I or Attending after death. Director; After	y the f	icati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury	- At home, farm, sti		Yes 2 □ No	28f. Location (St.	reet and Number or F	Rural Route Number,	
Div	d in b	Certification:	4 Homicide determined building, etc. /s	Specify)			City or Towr	n, State)		
Div Hospital or 24 hours afte	29a. Certifier (Check only 2 Dimedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner (Check only 2 Dimedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and of the cause of									
To the I	comp	Me	29b. Signature and title of certifier		29c. Licens		2	9d. Date signed (Mor	oth, Day, Year)	
					Wo	23371		HAMIC Z	-, 600/	
	6		30. Name and address of person who completed cause of death			ledical 1	2:10	Carl.	2, 2007 land Md. 215	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's	NSON HE Signature	()	rearcal j	DUITOUN	d' Lumpe	jana ja. A.	
Re	egistr	ar	MAY 0 2 2007	Signature	will					
DHMH 17 F	Rev 1/20	001	cost of the same							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Wright Walter John April 2007 2:20 a 17, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park
If Under 1 Year If Under 24 Hrs. Montgomery 9: Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours **tx**☐ M 2☐ F 87 Director 300-07-6152 2, 1919 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits M☐Yes 2☐No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or 5 "natural", or items 23a 20852 11410 Strand Drive, #403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 13 Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Speakhite þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Administrator Educational Study 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Walter B. Wright Helen Fenton 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Is r Georgia L. Wright/Wife 11410 Strand Drive, #403, Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages ' April 21 permit. Pages
Department of H
Important: If ite
any injury or of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 12 hours **Physician** andio ceur disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Swere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed Schau Due to (or as a consequence of) Physician/Medical certificate the as attending properties of the pr IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9☐Unknown 9 ☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 perform certificate Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA P 27. Mann r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident

Box 68760, Ö Records,

To the Hosp.....
within 24 hours after death.
To the Funeral Director: Aft

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

📆 Certifying Physician: Jothe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

6 □Could not be

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29d. Date signed (Month, Day, Year)

e of teath (Item 23a) (Type, Print) 30. Name and address of person who completed cau TAYAZ

31. Date filed (Month, Day, Year) 1 8 2007

Carroll Ave., Takoma Park, MD 20912 32#Registrar's Signature

7600

State Registrar

Medical

Division or Vital Records, P.O. Box 68760,

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year) 2007 APR 8 1

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29b. Signature and title of certifier

30. Name and address of person



who completed cause of death (Item 23a) (Type, Print)

29c. License number

8

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar/AMEND#7,8per:FH4/26/07,EMW,MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 5:15 a M Abe William Weissbrodt April 16, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 7. Age (In yrs. last birthday) 93 Yrs. 5. Social Security Number If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 🕱 M 2 🗆 F Director 020-10-7762 April 18, New York, New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mentalle Hyglene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event. the Medical Exercises 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits District of 1 X Yes 2 □ No Director Washington Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2510 Virginia Avenue, NW 20037 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. KEYes 2□No WWII Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No 2 Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lawyer Weissbrodt & Weissbrodt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Shloima Weissbrodt Rose Firestein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Weissbrodt - Wife 2510 Virginia Avenue, NW, Washington, DC 20037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Mt. Lebanon Cemetery 4/18/2007 Adelphi, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Aspiration Pneumonia /Medical Due to (or as a consequence of): **Examiner** Emphysema Sequentially list conditions, if any, leading to immediate cause. E. t. U. orlyl g Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe certificate 2K No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No I Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a 29a. Certifier 1 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 in Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signat title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D62949 April 16, 2007 leted cause of death (Item 23a) (Type, Print) d600 Old Georgetown Road, Bethesda, Maryland 20851 Natasha Haag, M.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR

18

∰gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 1008 200 Peggy Jenkins Woodward 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Washington County Hospital Hagerstown If Under 1 Year Pif Under 24 His . Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🗓 F Months Days Hours 228-38-2922 Virginia March 21 1932 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes X☐ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11818 Peacock Trail 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Karl Jenkins Rena Blose Jenkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11818 Peacock Trail Hagerstown Maryland 21742 Wayne Woodward (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Beaver Creek Cemetery 4-19-2007 Hagerstown Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home suuglos. 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARdovasa Due to (or as a consequence of): Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical **Examiner**

permit. Pages 1 and 2:
Department of Health a
Important: If Item 27 Is
any injury or other trau

Physician

/Medical

Examiner

10a. State

Director

Funeral

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and 2 should be filed within 72 hours after death with the Marylan eath and Mental Hygiene. To still and Mental Hygiene. To 33 or 28a-f show nor 12 is marked other than "natural", or Items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at

altimore, Maryland 21215-0036

burial-transit and physician the ! as attending p ed by the a detached f signed t Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica

The law requires that the death certificate be executed

P.O. Box 68760

Division or Vital Records,

Physician/Medical <u>م</u> Completed Be Certification: To

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

29a. Certifier

(Check only one)

Medical

5 Pending investigation 2 Accident 3☐ Suicide 4 Homicide

6 ☐ Could not be

2 X ER/Outpatient 3 □ DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D0063101

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) April 17, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ad 12931 Oak

and manner stated

Hagerstown Maryland

State Registrar

24 hours a

To the

completely

31. Date filed (Month, Day, Year) APR 19 2007



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Leonard O. Williams РМ April 14 2007 6:03 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 521 Coover Road Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 XM 2 ☐ F 110-24-1849 85 Director Nov. 4, 1921 England Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 28a-f show at Maryland Anne Arundel Annapolis 1 ☐ Yes 2 X No Examiner must be notified Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with "natural", or items 23a or 521 Coover Road 21401 U.S.A. by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event the Manany injury or other traumatic event the Manana Elementary/Secondary (0-12) College (1-4or 5+) Banker Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Edward Williams Elizabeth Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Ronald M. Dapkunas/nephew 611 Hollow Road Ellicott City, Maryland 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXxurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 4/18/2007 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of uneral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 todo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final irman **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy jo in the past 12 months? Year Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9☐Unknown 9 Unknown signed by Part II. Other significant contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð should be 20 No 1 Tes 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No. Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c_License number 29d. Date signed. (Month, Day, Year) 29b. Signature and title of certify 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 215 Ridgely Avenue Annapolis, Maryland Jack Lichtenstein egistrar's Signature APR 17 2007 State Registrar

in or Vital Records, P.O. Box 68760,		Baltimore, Maryland 21215-0036
ing Physician: The law requires that the death certificate be executed	Phy /M Ex:	permit. Pages 1 and 2 should be filed within 72 hours after death
After this certificate has been signed by the attending physician and		Department of health and mental riggiene. Important: if item 27 is marked other than "natural", or items 2
uneral director, page 2 should be detached for use as the hurial-transit	74.	any injury or other traumatic event, the Medical Examiner mus

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Daltimor permit. Pages Department of Important: if it	any inju		Da. Method of Disposition Date Date Community Date Community Date													
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DIVISION OF VITAL RECORDS, P.O. BOX 08/0U, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	ched for us	Physician/Me	in the past 13 1 ☐ Yes 2 9 ☐ Unknow	⊒Ectopic preg ⊒ Other <i>(sp</i> ec				23d. Date of delivery Month Day Year								
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/Medic Examin		Household of	ntion, give s Ange	treet and n	_{umber)} siste	d Livi	ng		Town, or l Sever		_		40	. County o		rundel	
Funeral Director	· ·	5. Social Security Number 213–20–2023	6. Sex		7. Age (In yrs. last bi 84	\rightarrow	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	ay, Year,		9. Birthp Coun	lace (State or Fo. try) MD	reign
iryiand show		Usual Residence of Deceden 10a. State 10b. Cou		undol	1	0c. City, Tov	vn or Lo		erna	Parl	ς				1	0d. Inside City Li	
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n • • •		Tom Codd/Nep 20a. Method of Disposition 1 ABurial 2 Cremai 4 Dopartion 5 Ø Othe	ion 3 🗆 P	Removal from State Drui			of Dispo		me of other place	ery 2007			20c. Location - City of Pikesvill				
Battimor permit. Pages Department of important: If it eny injury or o		21. Signature of Funeral Se		80	0 -		B	arran	nd Addres	s Sons			/erna	a Park Funer a Park, MD		neral Ho	me
8760, rate be executed by sicien end the burial-transit the burial-transit	dical Examiner	23a. Party. Ent if the diseas shock, or learn failure. Impediate Cause (Final disease or cordition resulting in death) Sequer lially list conditions, if any leading to immediate susse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e, of corton	Due	to (or as a	he death. Do	e of):	ter the mod	de of dying	g, such a	s cardiac	or respiratory	arrest,			Approximate Interval Betwee Onset and Dea	th
Cords, P.O. Box 6i w requires thet the death certific been signed by the attending p should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnal in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	of pregnancy 2 Petal dea ime of death	Fetal death 3 Ectopic pregnancy						23d. Date of de Month			rery Day Yea	ır			
dS, P. uires thet to signed by	۵	Part II. Other significant co	enditions co	entributing to	o death bu	2 1		3	cause give	en in Pari	l.			o use cont		the cause of deathbably 4 Dunk	
Recor	Completed	Altzheimers disea										24a. W au pe 1 🗆 Ye	utopsy erformed	?	Were aut prior to c death? 1 Yes	opsy findings ava ompletion of cause 2 No	allable se of
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician end compiletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ertification: To Be C	2 Accident	ending ivestigation	28a. Da (A	☐ Inpatier ate of fnjun fonth, Day	Year) 28t	Time Injury	of M	28c. Injur Wor 1 🗆	er: 4 🗆 f	Nursing H	ath (Check on lome 5 □ R 28d. Descri	esidence be how in	ijury occur		L) VIV.	9
Divis	Certific	3 Suicide 6 C	ry - At home :. (Specify)						City or	Town, St	reet and Number or Rural Route Number, n, State)			Γ,			
To the Hospital within 24 hours a To the Funeral I completely filled	edicai (29a. Certifier Ce (Check only 2 Me	rtifying Ph dical Exem	iner: On th	the best one basis of nanner sta	examination	owledge, death occurred at the time, date and place, and due to the ca tion and/or investigation, in my opinion, death occurred at the time, da						ne, date a	date and place, and due to the cause(s)			
To the withing To the comp	W									29c. License number 29d 20029571 0					0 4 /1 3/2 0 0 7		
5		30. Name and address of p	29	MD	2229	JE!	Det	Print)	e H	wy	CI	rofte	n,	MO	2	1114	
S Regis	tate trar	31. Date filed (Month, Day,	1 6 2	007	2. Pojistra	ar's Signature)										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 21, 2007 **Physician** Month Wayne 10:30 a^M Robert Watkins April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 23095 Sweet Bay Lane California St. Mary's 7. Age (In yrs. last birthday, If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1X M 2□ F Director 488-48-9880 <u>61</u> 11/14/1945 Missouri Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if item 27 is marked other than "networth" any injury or other than 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23095 Sweet Bay Lane 20619 Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married 1 ☑ Yes 2 If Yes, Give 2 □ No 1 ☐ Yes 2 No þ Specify White 3 Widowed 4 Divorced ear or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Marine Naval Aviator U.S. Marine Corps. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be r Oniece Embrey Lindell Watkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane L. Watkins/ Wife 23095 Sweet Bay Lane, California, Maryland 20619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Ce.06/28/2007 Arlington, Virginia 21. Signature Funeral Service Lice see 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield Jr. M00052 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician disease or condition resulting in death) ste /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter third-riying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed fler death.

Director: After this certificate has been signed by the attending physician and and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No perform 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Stesidence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide within 24 hours To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature In title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D62288 April 23, 2007 ess of person who completed use of death (Item 23a) (Type, Print) Three Notch Road, Hollywood, Maryland 20636 Nikkal, 24035 32 Registrar's Signature 31. Date filed (Montl State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** LESTER ROCHE WOODALL, JR. 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deatl Examiner if Under Social Security Number Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months Min. 1 X M 2 □ F 83 Director 454-18-7754 JULY 31, 1923 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Muclical Examiner must be notified. Director MARYLAND QUEEN ANNE'S **GRASONVILLE** 10e. Street and Number 10f. Zip Code 21638 44 PROSPECT BAY WEST Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **ENGINEER** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LESTER ROCHE WOODALL, SR. MARION ROBINSON ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44 PROSPECT BAY WEST, GRASONVILLE, MARYLAND 21638 LINDA WOODALL/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition APRIL 11, 3 Removal from State 1 X Burial 2 ☐ Cremation 5 Other (Specify) WOODLAWN MEMORIAL 2007 4 ☐ Donation 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause preach line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a. Was an autopsy perform 2 No il or Attending Physician: after death. I Director: After this certifica pletely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral DI 29a. Certifier 1 🔽 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

PENNSYLVANIA 10d. Inside City Limits 1 ☐ Yes 2 X No 10g. Citizen of What Country? UNITED STATES Black, White, etc. WHITE Specify: 16b. Kind of Business/Industry TELEPHONE COMPANY 20c. Location - City or Town, State EASTON, MARYLAND Approximate Interval Between Onset and Death year 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) St., Easton, MD 21601 Washington

Birthplace (State or Foreign Country)

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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		l-For State Registrar			C	ertifica	ate of i	Death				Reg. N	0				
Physicia		Decedent's Name (First, Middl	e,Last)						-	2	Date of De	eath			3. Time of Death	_	
edical Examin	er	CATHERINE EVERE	TT W	ESSEL							Month April 1, 2	2007	y Year		1411 hrs		
· Anna		4a. Facility Name (if not institutio Memorial Hospital	n, give str	eet and nu	ımber)		4b	. City, Town, or Easton	Location o	f Death			4c. County o Talbot	f Death			
Funeral	┪	5. Social Security Number	6. Sex		7. Age (In yr	s. last birt	hday)	If Under 1 Yea	r If Under	r 24Hrs.	8. Date of B	Birth(M	M/DD/YYYY)		place (State or	-	
Director		453-11-7680	1 M	2 X F	2	6	Yrs.	Months Day	s Hours	Min.	TIME	20	1070	Foreign Cou	ntry) TEXAS		
	-	Usual Residence of Decedent				0	110.				JUNE	20,	19/0		IEAAS	\dashv	
any		10a, State 10b, County			10c. C	ity, Town	or Locatio	n				_			10d. Inside City Limit	S	
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72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho af Examiner must be notified at once.	<u>.</u> 2	10e. Street and Number 4705 MAIN STREE	Т					10f. Zip Code 21638					itizen of Wh				
with th ns 23a be noti	ᇍ	11. Marital Status	12		cedent Ever in	u.S.	13. Was	Decedent of His					14. Race	- Americ	an Indian, Black,	\neg	
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after al", o	ᆰ	3 Widowed 4 Div	orced If Ye	es, Give Yea			1 🔲 🗅	res 2 X No	specify:				Specify:	WHI	TE		
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5-003 iled withi Hygiene. I other th	أق	17. Father's Name (First, Middle,	Last)						18. Mother's	s Name (F	lame (First, Middle, Maiden Surname)						
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica		ROBERT WYNHOFF							PAUL	A D.							
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imore, MD 2 Pages I and 2 shoul nent of Health and In iant: If item 27 is not other traumatic		EUGENE S. WESS	EL/H	USBAN	D	4	705 M	AIN STR	MARYLAND 21638								
e, ME I and 2 s Health ar item 27		20a. Method of Disposition					of Dispositi ory or othe	ion (Name of ce	metery,		Date TT 3	20	c. Location -	ation - City or Town, State			
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	-	4 Donation 5 Other Sa 21. Signature of Funeral Service	e <i>cify:</i> 4-ice ee			HESAPEAKE CREMATION 2007 STEVENSVILLE, MAI									E, MAKILA	IN	
Balt permit. Depart Impor injury	Į	1/1	2000	1 6.	1106 SHAMROCK ROAD, CHE								AND NEWNAM FUNERAL HOME, I				
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/Medical		failure. List only one cause	on each li	ine.										- 3	Between Onset and Death	d	
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		or container rocaling in accum,	bue	to (or as a	a consequenc	sequence of):											
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687 ertifi ding e as t	an/	23b. Was decedent pregnant in the past 12 months?] '	Live		f dooth	=	al death 3	Ectopic	pregnan	су		Month	D	ay Year		
Box 68 death certificate attending and for use as	sic	1 Yes 2 No 9 V Uni	known c	Unkn	nant at time o	death (5 Oth	er (Specify)									
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tal Re(tian: The certificate	ပ္	25. Was case referred to medica	1					26 Plac	e of Death ((Check or	nly one)						
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Division tal or Attendi rs after death. al Director: /	Certification:	dete	ld not be rmined	(Specify			,		J.		or Town						
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	Chack only Certifying P	hysician: miner:Or	וס the be the basis	st of my know of examination	neage, ae on and/or i	atri occurri investigatio	on, in my opinio	n, death oc	curred at	the time, da	ite and	place, and d	ue to the	cause(s)		
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		0. Name and address of person						444.5			NAD SIE	0.4	exelicit-				
		Theodore M. King, Jr.			ant Medica		iner '	111 Penn Si	reet, Ba	itimore,	, MD 212	U1					
State 31. Date filed (Month, Pay, Year) 4 2007 32. Registrar's Signature																	
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07-03032 Michael Rae Wilt

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			- For State	Cer	rtificate of	Death		1	Reg. No	D	2. Time of Death
f	Physicia xamir	n/	egistrar 1. Decedent's Name (First, Middle,Las Michael	RAE Wilt					Day 0, 2007		15501115
			4a. Facility Name (if not institution, giv 2278 Michael Road			4b. City, Town, o Barton	r Location of Dea			4c. County o Garrett	
	uneral Director		5. Social Security Number 6. Social Security Number 1. Social Security	7. Age (in yrs. I	last birthday) Yrs	If Under 1 Year Months Day			of Birth(MI		9. Birthplace (State or Foreign Country)
21215-0036	uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f show any event, the Medical Examiner must be notified at once.	_	Usual Residence of Decedent 10a. State 10b. County Allegan 10e. Street and Number 20616 Hcrsick 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorce 15. Decedent's Education (Specify of the county) 17. Father's Name (First, Middle, Las Richard Scholard) 19a. Informant's Name/Relationship 100144 Rac William	Cond S. W. 12. Was Decedent Ever in L. Armed Forces? 1 Yes 2 X No d If Yes, Give Year or Dates: Only highest grade completed) College (1-4 or 5+) C Type, Print) The wife	J.S. 13. Was If Y 1 16a. Deceder during m	as Decedent of Hyes, specify Cuba Yes 2 N Not's Usual Occup most of working li	dispanic Origin? (an, Mexican, Puer No specify: Deation (Give kind of ife. DO NOT use of Miner 18. Mother's Na Rose reet and Number CK Ron-	Specify Yes erto Rican, etc of work done retired) ame (First, Mi	or No-c.)	14. Race White Specify: b. Kind of Butter Surname for use	e - American Indian, Black, e, etc. White usiness/Industry OAI
Baltimore	permit. Pages I and Department of Heal Important: If item injury or other tra		20a. Method of Disposition 1	Removal from State fy: ensee Indications that caused the dea	crematory or o	Memoria	1 PACK AL	or.124,0	2007	Frosto	burg Maryland
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D O Box 68760	te death certificate attending	by Physician	past 12 months? 1 Yes 2 No 9 Unknot Part II. Other significant condition	9 OIKHOWH	2 f death 5	Fetal death Other (Specify) ne underlying cau	3 Ectopic pr			2 🗸 No	ntribute to the cause of death? 3 Probably 4 Unknow
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4	VICAL I ysician: his certifi	a a	examiner?	Hospital: 1 Inpatient 2	ER/Outpati	ient 3 DOA	Other ₄	Nursing Home			6 Other: Scene
	n or v ding Phys h. : After thi	ਰ ⊢	27 Manner of Death	28a. Date of Injury (Month, Day, Year) Apr 17, 2007	28b. Time 0920 hrs		. Injury at Work? ✓ Yes 2 N	_{√o} Minin	ng accide		
	DIVISION DIVISION Spital or Attendi hours after death. meral Director: A	Cartification.	2 Accident Investi 3 Suicide 6 Could determ	not be 28e. Place of Injury - /	At home, farm, s	street, factory, of	fice building, etc.	I 0	r Town St		imber or Rural Route Number, C on, Md.
	To the Hospital within 24 hours To the Funeral	completely filled	4 Homicide 29a. Certifier (Check only one) 2 Medical Exam	rsician: To the best of my know	wledge, death on on and/or invest	ccurred at the tim tigation, in my or	ne, date and place pinion, death occu	e, and due to	the cause me, date a	nner as stated. nd due to the cause(s)	
	To the within 2	lwoo	29b. Signature and title of certifier	and manner stated.		29c. L	29d. Date s	Date signed (Month, Day, Year)			
			30. Name and address of person v	who completed cause of death				<u> </u>			
		6		stant Medical Examiner	· 111 Pen	ın Street, Bal	Itimore, MD 2	21201			

07-03241 Glenn Douglas /		ns 1-ForState Amend 1	pe or Print i tate of Maryl tem 4c per						giene		2 O O	7 1423	
Physicia Medical Exami	an/	1. Decedent's Name (First, Mid-	dle,Last)				-	2.	Date of De Month April 28,	eath	Year	3. Time of Death 1140 hrs	
¢ .		4a. Facility Name (if not institut	ion, give street and n	umber)		4b. City, Town	, or Location		April 20,	4c. Co	Inty of Dea	th	
		6636 Washington Blv 5. Social Security Number	6. Sex	7 Ago /In wm	s. last birthday)	Elkridge	Voes If Und	ler 24Hrs.	9 Date of F			Howard irthplace (State or	
Funeral Director		577-66-3061	1X M 2 F		0	Months	Days Hour			3-1946	Fore		
	-	Usual Residence of Decedent	121 M 2 F	<u> </u>	rs.		1_1	12-0	3-1340		VIIgIIIIa		
any	- 1	10a. State 10b. County	/	10c. C	ity, Town or Loc	ation						10d. Inside City Limits	
and f show	5	MD Howa				1 Yes 2 X No							
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number				10g. Citizen		untry?					
ith the 23a o		6636 Washing				210					.S.A.	vices Indian Black	
r death w or items	Funeral	11. Marital Status 1 Never Married 2 X	Married Armed I		If	Vas Decedent of Yes, specify Cu					White, etc.	erican Indian, Black,	
fter de l'', or		3 Widowed 4 D	ivorced If Yes, Give Yes	2 No	_	Yes 2 🗶	No specify	<i>r</i> :		Spe	cify: Wh	ite	
iours a	d b	15. Decedent's Education (Sp	ecify only highest gra	ade completed)) 16a. Deced	ent's Usual Occ most of working				16b. Kind	of Business	s/Industry	
5-0036 led within 72 hours after Hygiene. other than "natural" the Medical Extension	Completed	Elementary/Secondary (0-12	College ((1-4 or 5+)		-			-/	Po		Class Ca	
5-0036 ifed within 72 Hygiene.	omo		e. Last)		wal	e nouse			irst. Middle			Glass Co.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Hand Mental Hygiene. Important Size and Size of the than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Bec										,		
21. nould 1 is mar tic ev	2	19a. Informant's Name/Relation	nship (Type, Print)		19b. Maifi	ng Address (S					Town, Sta	te, Zip Code)	
, MD 2121: and 2 should be fil lealth and Mental I tem 27 is marked traumatic event,			- Wife	Lan						34, E	lkrid	ge, MD 21075	
MOre, Pages I an nent of Hea ant: If iter		Ware House Manager Banner Gla 7. Father's Name (First, Middle, Last) Woodrow J. Adams 9a. Informant's Name/Relationship (Type, Print) Linda Adams – Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zp. Linda Adams – Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zp. Linda Adams – Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zp. 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery 5/7/2007 Crownsville											
timent rants		Woodrow J. Adams Informant's Name (First, Middle, Last) Linda Adams — Wife Linda Adams — Wife Many A. McTier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Companies) Linda Adams — Wife Linda Adams — Wife Many A. McTier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Companies) Linda Adams — Wife Many A. McTier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Companies) Linda Adams — Wife Many A. McTier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Companies) Date 20b. Place of Disposition (Name of cemetery, crematory or other place) Donation 5 Other Specify: Maryland Veterans Cemetery 10d Crownsville, 22. Name and Address of Facility 4739 Baltimo											
Baltin permit. Departm Importa		21. Signature overuneral Service		le, MD 20781									
Physician		23a.,Part I. Enter the disease, o		caused the dea							Approximate Interval		
/Medical		failure. List only one caus Immediate Cause (Final diseas	Adheunant	erotic Cardi	ovascular Di	isease						Between Onset and Death	
A Common		or condition resulting in death)	200 10 (0. 00	a consequence	e of):		100	- 56					
	ē	Sequentially list conditions, if any, leading to immediate		a consequence	e of):								
Š	Examiner	cause. Enter Underlying Caus (Disease or injury that initiated	C.	a consequence	e of):								
ecuted and transit		events resulting in death) Last	d.	a consequence	e 01).								
	cian/Medical	UNPENDED	AMENDED)									
Box 68760, e death certificate be the attending physic of for use as the burned for use	/Me	IF FEMALE: 23b. Was decedent pregnant in	the .	, outcome of pr							te of delive	_	
certif certif ending use as	cian	past 12 months?	Live	birth gnant at time of	doath	etal death Other (Specify)	3Ectop	ic pregnanc	у	Mor	nth	Day Year	
Boy e deatl the att	Physic	1 Yes 2 No 9 U	nknown g Unki	nown		Ourion (-p)/							
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be ex After this certificate has been signed by the attending physician tuneral director, page 2 should be detached for use as the burial	by P	Part II. Other significant cond	litions contributing	to death but no	at resulting in the	e underlying cau	ise given in P	Part I.		*******		o the cause of death?	
duires en sign									24a. Wa			autopsy findings available	
SOFC faw re has be	Completed	·							aut	opsy formed?		completion of cause of	
Re(: The fficate f, page	S	05.14				00.5		/Oh l		2 ✔ No	1 🔲 '	Yes 2 No	
/ital sician is cert	Be	25. Was case referred to medic examiner?	Hospital:	Inpatient 2	ER/Outpatie		Other		Home 5	Residence	6 ✔ Oth	er: Scene	
n of V ling Phy After th funeral d	۲: 1	1 Yes 2 No 27. Manner of Death	28a. Dat	e of Injury			Injury at Wor		-				
ion tendin eath tor: A	atio		nding	itii, Day, real)		1[Yes 2	No					
Division of Vital Records, infal or Attending Physician: The law requirurs after death raral Director. After this certificate has been silled in by the funeral director, page 2 should b	ertifica	250. Uste of injury 250. Imme of injury 250. I										Rural Route Number, City	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ex- within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Town, State) 28g. Certifier (Check only one) 28g. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner of the desired of the death occurred at the time, date and place, and due to the cause(s) and manner of the death occurred at the time, date and place, and due to the cause(s) and manner of the death occurred at the time, date and place, and due to the cause(s) and manner of the death occurred at the time, date and place, and due to the cause(s) and manner of the death occurred at the time, date and place, and due to the cause(s) and manner of the death occurred at the time, date and place, and due to the cause(s) and manner of the death occurred at the time, date and place, and due to the cause(s) and manner of the death occurred at the time, date and place, and due to the cause(s) and manner of the death occurred at the time, date and place, and due to the cause(s) and manner of the death occurred at the time, date and place, and due to the cause(s) and manner of the death occurred at the time, date and place, and due to the cause(s) and manner occurred at the time, date and place, and due to the cause(s) and manner occurred at the time, date and place, and due to the cause(s) and manner occurred at the time, date and place, and due to the cause(s) and manner occurred at the time, date and place, and due to the cause(s) and manner occurred at the time, date and place, and due to the cause(s) and manner occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and d												
F F F 8	Me	29b. Signature and title of certif		// /			cense number	r			-	fonth, Day, Year)	
		MIC	AL /				.C.M.E.			May 1,	2007		
1th		30. Name and address of person Susan Hogan MD.	on who completed car Assistant Madi			enn Street, E	Baltimore	MD 212	01				
6.	oto	31. Date filed Many Day, Year		Registrar's Sign		an ouser, L		2 120					

Registrar

riease Type of Print in Black Indelible ink. Ensure All Copies Are Legible.	
State of Maryland / Department of Health and Mental Hygiene	2007
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'illie Lee Allen	1		e of Maryland / Depar					e.	07 14238
		1- For State		tificate of		ı Mentanı			U / INCOC
Physici	ian/	Registrar 1. Decedent's Name (First, Middle,La					2. Date of Death		3. Time of Death
le∹'cal Exam		Willie	Lee		Allen	ı	Month April 24, 20	Day Year 007	0155 hrs
		4a. Facility Name (if not institution, g	<i>'</i>	4	b. City, Town, or I	Location of Dea	ath	4c. County of D	eath
		5122 Queensberry Aven			Baltimore		1		
Funeral		Onk	Sex 7. Age (In yrs. lat		If Under 1 Year Months Days		din.) Fo	Birthplace (State or preign
Director		1/2	Хм 2 F 43	Yrs.	World bays	Tiodis IV	b8 07	63	Country) MD
any		Usual Residence of Decedent 10a. State 10b. County	Inc City	Town or Location	ND.				10d. Inside City Limits
		ŕ							1 Yes 2 No
faryland 28a-f show	햙	MD N2 10e. Street and Number	A Ba	ltimor	10f. Zip Code		110	g. Citizen of What	21
e Mai or 28	Director		cress Asso		·	1015			
vith th	a [5122 Queensber	12. Was Decedent Ever in U.S	13 Was		1215	Specify Yes or No-	U - S	• A • merican Indian, Black,
eath v items	Funeral	1 Never Married 2 X Marrie	Armed Forces?		s, specify Cuban			White, et	
fter d	핏	3 Widowed 4 Divorce	1 Yes 2 X No	1	Yes 2 X No	specify:		Specify:	Black
ours a atura camin	d by	15. Decedent's Education (Specify	only highest grade completed)		s Usual Occupati			16b. Kind of Busine	ess/Industry
5 72 ho 2a Es	lete	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	st of working life.	DO NOT use r	<i>'</i>		TIC .
5-0036 fled within 7 Hygiene. I other than the Medica	Completed	12th grade	na		Sales			Various	Jobs
filed v Hygi doth the	ျပို	17. Father's Name (First, Middle, Las					me (First, Middle, M	,	
2121 Muld be fi Mental J marked c event,	o Be	Willie Lee All 19a. Informant's Name/Relationship		T10h Mailing			e McAll		No. 1 7: 0 - 1 - 1
MD 2 d 2 shou lth and N n 27 is n	2				`				,,
and 2		Paulette Aller 20a. Method of Disposition	20b. P	lace of Disposit	tion (Name of cen	Netery,	ne Ct, C	20c. Location - Cit	y or Town, State
ages 1 nt of 1 t: If		1 K Burial 2 Cremation 3	Tellioval Ilolli State	rematory or oth		D =1 =	: /2 /07	D 3 11	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland bepartment of Health and Mental Hygiene Other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		4 Donation 5 Other Special Structure of Funder Service Lice			orial		0/2/01	Kandall	stown, Md
Dep Dep Inju		Inetto	K- Jone-)	Ma	rch F/	H West	: re. Balt	4	Md 21215
Physician		23a. Part I Enter the disease, or confailure. List only one cause on	nplication that caused the death.	Do not enter the	e mode of dying,	such as cardia	c or respiratory arre	st, shock, or heart	Approximate Interval
Medical			a. Cocaine and narco	tic into	xication				Between Onset and Death
xaminer	or condition resulting in death) Due to (or as a consequence of):								
	Ļ	Sequentially list conditions,	b						
	aminer	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of)	1:					
K o i	Exan	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of)	1:					
and trans	dical E		d						-
O, the existian	l eg	X UNPENDED	AMENDED, 27, 28a-f, p	erME,G86	7,5/10/07	TT			
Box 68760, eath certificate be the attending physicised for use as the buring control of the buring	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregn	ancy	al death 3	Ectopic preg	nancy	23d. Date of del Month	ivery Day Year
× 64 h cert tendir	icia	past 12 months?	4 Pregnant at time of dea		er (Specify)	Lotopio piog	, namo y	The state of the s	Day 10di
Bo e deat the at ed for	Phys	1 Yes 2 No 9 Unknow	yn g Unknown						
P.O. s that the	by P	Part II. Other significant conditions	s contributing to death but not re-	sulting in the ur	nderlying cause g	iven in Part I.			e to the cause of death?
S, P.(uires that n signed ld be deta	ed t	ļ. —————					_ 1 Yes		Probably 4 🗹 Unknown
Records, The law require ficate has been si, page 2 should b	Completed						24a. Was a autops	sy prior	e autopsy findings available to completion of cause of
Rec The la cate h	Ĕ						perform 1 ✓ Yes 2		h? Yes 2 No
tal Rection: The certificate ector, page	Be	25. Was case referred to medical examiner?			1	of Death (Chec	ck only one)		
of Vital ng Physician: After this certi nneral director	2	1 ✓ Yes 2 No		ER/Outpatient				Residence 6 🗸 C	Other: Scene
n of ding Pl		27. Manner of Death 1 Natural 5 Pending	(Month, Day, Year)	28b. Time of In		y at Work? 'es 2 X No	28d. Describe h unk	ow injury occurred	
Sior Attend death ector:	cati	2 Accident Investiga	ation FIRE 4/24/2007	Fnd 1:30	aiii				
Division Ral or Attendii rs after death. al Director: Aled in by the fu	Certification:	3 Suicide 6 X Could no determin		me, tarm, street	i, factory, office bi	uilaing, etc.	or Town, St	ate)	r Rural Route Number, City
ie ou		29a, Certifier	110use	o dooth s:	ad at the time	to and -is			e. Baltimore, MD
To the Howithin 24 F	lical	(Check only Certifying Physi	cian: To the best of my knowledger: On the basis of examination an						
To To Com	Medical	29b. Signature and title of certifier	and manner stated.		29c. License			29d. Date signed	
	_	1/1/11	V 0/ _		O.C.N			April 24, 2007	
_		30. Name and address of person who	completed pause of death (Item)	23a)					
Q.		Theodore M. King, Jr., M			111 Penn Str	eet, Baltimo	ore, MD 21201		
	tate	31. Date filed (Month, Payayear) 00	22. Registrar's Signatur	· Coast	1	· · · · · · · · · · · · · · · · · · ·			
Regis	trar	MAY U S ZUU	1	1					

Please Type or Print in Black Indelible Into Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1	-	For Stete Registrar				
T1	- D	ecedent's !	Vame	(First	Middle	

7		11	-1	
Reg. No.	U		ě	

14239

28f. Location (Street and Number or Rural Route Number, City or Town, State)

			1 - Stete Registrar			Certificate	of Death		Reg. No.	UI	14609
1	Physici	an	1. Decedent's Name (First, Middle,		10			2. Date of D Month		Year	3. Time of Death
	/Medic	al	DONALD 4a. Fecility Name (If not institution,	ARMSTRO!	-	4h City 3	own, or Location of D	APRIL	25 4c Cow	200 7	10:55AM
	Examir	ier	POTOMAC VALLE		1235 Pete	noc Roo	KVILLE	eatt i		TGOM	
e Z	Funeral Director		5. Social Security Number 579 38 2572	14	ge (In yrs. last bin	hday) If Under Months Yrs.	Year If Under 24	in. (Month, L		9. Birth	pplace (State or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	death with the Maryland ems 23a or 28a-f ahow ems the notified at	tor	MD MOR	ITGOMERY	ROCK	VILLE					1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number	1		10f. Zip			10g. Citizen o	f What Col	untry?
	s 23a	ral	13101 EVANSTON				20853		United		
336	after or fte	by Funeral	11. Marital Status 1 Never Married 2 Marne 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	? No	13. Was Deceded If Yes, special 1 Yes 2	ent of Hispanic Origin' fy Cuban, Mexican, Pi No Specify:	(Specify Yes or ruerto Rican, etc.)		lack, White	rican Indian, a, etc. HITE
2-0	72 hours "natural",	eted	15. Decedent's (Specify only highest	Education	16a.	Decedent's Usual	Occupation done during most of	workina	16b. Kind of	Business/I	ndustry
Maryland 21215-0036		To Be Completed	Elementary/Secondary (0-12)	College (1-4or		`life. DO NOT usi eman	e retired)		Lumb	0.7	
d 2	e filed withing the Hygiene. other then yant, the Hygiene.		17. Father's Name (First, Middle, La	ast)	1202	Cincin	18. Mother's	Name (First, Midd		_	
<u>/lar</u>			Percy Armstrong Betty Elizabeth Berrett								
Man			19a. Informant's Name/Relationshi Donna Kerler /			-	(Street and Number of hill Road		,		
<u>6</u>	s 1 and 2 if Health item 27 i		20a. Method of Disposition		20b. Place of	Disposition (Nam	e of	Date	20c. Locatio		
ЭЩ	Page nent o ent: If ury or		1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	_)		BCARD D	4-25-200	F BALT	IMORY	e, mo
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Li	censee VV			Address of Facility A			-	
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cause nly one cause on each I	d the death. Do r				arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a	ngue	lasc	inome				Officer and Double
	Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions, b. A CLE Ren C Facillure.								
_		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	as a consequence of):						
V	ecuted and -transi	Examln	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to force	s a consequence	261					
.60	ertificate be executed ling physicien and se as the burial-transit			Due to (or as	s a consequence	סו):					
68760,	ificate g phys as the	Medical		d							
O. Box	The law requires that the death certific tte hes been signed by the ettending p bage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 ☐ Fetal death at time of death	3 □Ectopic pre 5 □ Other (spe			1	Date of delig Month	very Day Year
ď.	s that ined b e deta	by Pt	Part II. Other significant condition	is contributing to death t	but not resulting in	the underlying ca	use given in Part I.	23e. Dio	tobacco use co	ontribute to	the cause of death?
ırds	w require been sig should b		Dene	119				1[Yes 2□No	res 2□No 3□Probably 4★Unknown	
ion of Vital Records,		Completed						per per	as an 24l opsy formed? 2 1 No	death?	topsy findings available completion of cause of 2 2 No
/ita	Physician; The latthis certificate her ral director, page (Be	25. Was case referred to medical examiner?	Hospital			1 1	Death Check only			
of	Phy this ald	5.	1 ☐ Yes 2 No 27. Manner of Death		ient 2 ☐ ER/Ou urv 28b. 1			g Home 5 □ Re	sidence 6 🗆 0		rify)
ion	ath. r: After	atlon;	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Inju (Month, Da	ay Year)	njury M	lc. Injury at Work? 1 ☐ Yes 2 ☐ No	234. 2030(10)			

To the Hospital or Attanding F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.

Certificatio

Medical

3 Suicide

29a. Certifier

4 | Homicide

DHMH 17 Rev 1/2001

SAYED 31. Date liled (Month, Day, Year)

29b. Signature and title of ce

investigation 6 Could not be determined

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 0 0 0 6 2 4 3 5

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

ORIGINAL

State Registrar

hades St. Balts. M& 2120x

			State of Maryland /	Department of Health and N	lental Hygie	ene	1101
		•	1 - State Registrar	Certificate of Death	Reg	j. No. 2 U U /	1454
1	Dhusisi		1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Lillian M.	A11man	May	1, 2007	5:03A M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
. 24.5	· · · · · · · · · · · · · · · · · · ·		Gilchrist Hospice at GBMC	Towson		Baltimor	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit 164-20-8946 1□ M 2☒ F 82	rthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) Feb. 7,	9. Birth Co.	place (State or Foreign ntry) PA
	pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tov	n or Location			10d. Inside City Limits
	e Maryle a-f shov iffied at	ctor		ott City			1 ☐ Yes 2 No
	th the	Sire	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cou	ntry?
	23a ust b	la l	12102 Fredrick Road	21042		U.S.A.	
336	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ Molowed If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify:	
15-0	"natural";	eted	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ting 16	6b. Kind of Business/li	ndustry
21215-0036	ges 1 and 2 should be filed within 72 ho tt of Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, the Medical	Be Completed	Elementary/Secondary (0-12) College (1-4or 5+) 1 2	Hostess		Restauran	t
pu	al Hy t othe	Be (17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma	aiden Surname)	
yla	Ment Ment arkec	၉	George Bickleman	Olive			
Maryland	12 shd h and 7 is m traum		19a. Informant's Name/Relationship (Type. Print) 19 Mrs Melody Pullin / Daughter	b. Mailing Address (Street and Number or Rui		*	
e,	1 and Health em 27			6565 Belmont Woods R		Lage, MD Z.	
Baltimore,	permit. Pages 1 and 2: Department of Health an Important: If item 27 is any injury or other trauonce.		ADDonation 5 Other (Specify) Glen	Haven Mem. Park 20	4, 07	Glen Burn	ie, MD
Ball	Depart Import any in		21. Signiture of Fluneral/Service Licensee M 0 1 304	22. Name and Address of Facility Sin 1 Second AVenue SW	ngleton F Glen Bur	uneral Hom	ne, P.A. .061
	100		23a. Pri 1. Enter die mease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
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00	aw require s been si s should b	lete			24a. Was an	24b. Were aut	opsy findings available
Re	sician: The law certificate has b irector, page 2 s	E E			autopsy performe	prior to o death? ☐No 1 ☐ Yes	ompletion of cause of 2 12 No
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	ne Hospital or Attendi n 24 hours after death. ne Funeral Director: A bletely filled in by the fi	Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge of the control of the basis of examination a and manner stated.	e, death occurred at the time, date and place nd/or investigation, in my opinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the I within 2 To the I	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Month	
	1		M Chathan llile in	0 025205	V	MAYI,	2002

30. Name and address of person who completed cause of seath (Item 23a) (Type, Print)

32. Registrar's Signature

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** /Medical 10:30 PM Hilda Allen 4a. Facility Name (If not institution, give street and number) April 30, 2007 4b. City, Town, or Location of Death Examiner Baltimore Baltimore 7409 Belmont Avenue If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 🖫 F Director 83 02/03/1924 England Usual Residence of Decement Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygjene. 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a State 1 ☐ Yes 2 No Baltimore Baltimore Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code England 7409 Belmont Avenue 11. Marital Status 1 □ Never Married 2 Married 2 □ Windowed 4 □ Divorced 7 □ Windowed 4 □ Divorced 7 □ Windowed 4 □ Divorced 7 □ Windowed 4 □ Divorced by Funeral 21224 13. Was Decedent of Hispanic Ongin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify: Specify 16b. Kind of Business Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Teresa Phillips Samuel Mann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any Injury or other trauonce. 7409 Belmont Avenue Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Herbert Allen/Husband 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cermation 3 ☐ Removal from State May 3 4 □ Donation 5 □ Other (Specify) Beltsville, Maryland Chesapeake Crematory 21. Signature of Funeral Service Licensee Cremation and Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory areas, list only one cause on each line. Interval Between Onset and Death 3 m m Th s Immediate Cause (Final Cance Cell mall **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown has been si e 2 should l Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

To the Hospital or Attending Physician: Director: After this in by the funeral dir within 24 hours a

Registrar

Medical

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(Check only one)

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31. Date filed (Month, Day,

29b. Signature and title of certifier

29a. Cerlifier

DHMH 17 Rev 1/2001

and manner stated

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year) MAY 0 3 2007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D54841

29d. Date signed, (Month, Day, Year)

0

Philadelphia Rd Suite 208 Balto, My 21331

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 2007 **Physician** Rebecca Ruth April 25 9:55 A^{M} Birch /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death Examiner Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Y Jan. 28, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Hours Days Min 1 □ M 2 🗓 F 58 ΚY **Director** 231-64-0097 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Montgomery Bethesda MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 6304 Greentree Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Consultant Promotional 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melvin Birch Alice Simons ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joshua Rocchio (Son) 5018 Aspen Hill Rd., Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial__2 XCremation 3 ☐ Removal from State Metropolitan Crematory 4/29/07 4 ☐ Domation 5 ☐ Other (Specify) Alexandria, VA Applebee-McPhillips Funeral Home, 130 Highland Ave., Middletown, NY 21. Signature of Funeral Service License Unna Aneu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a. Acute Massive Pulmonary Embolism disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to jor as a consequence of use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year 5 ☐ Other (specify) signed by the at the detached for P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by Alcohol Abuse 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe certificate 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this filled in by the funeral 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year 1 Natural 5 ☐ Pending investigation 1 Yes 2 No after death. 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a

To the Funeral I 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely i (Check only one) 29b. Signature and tille of contifier 29c. License number 29d. Date signed (Month, Day, Year) D-20535 April 27, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6410 Rockledge Dr. #200 Bethesda, MD 20817 Jr. MD Roger Stevenson, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 2 per doc 967 5-9-07 vt.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 **ESKA** APRIL 11:07 p MURREL BRANNON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FOREST HILL HEALTH AND REHABILITATION HARFORD FOREST HILL If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 ☐ M 2 💢 F 95 July 19, 1911 West Virginia Director 236-40-1481 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be norificad and once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 📉 No Directo Harford Fallston Maryland | 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21047 U. S. A. 519 Stratford Road Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Completed by Specify 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stella Ross ၉ Price Jarvis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 519 Stratford Road, Fallston, Maryland 21047 Enona Phipps (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/01/2007 | Spencer, West Virginia Eventide Cemetery 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee Stefaerie 9705 Belair Road, Baltimore, Maryalnd 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 🗆 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Nunknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 033332 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID DUNN - 615 W.

Registrar

State

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

MACPHAIL ROAD - BEL AIR, MD 21014

			1 - For State Registrar	State o	f Marylar		artment of				giene	007	R metal	245
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			30. Name and address of person w	no completed caus	e of death (Item		Print	,		72	7			
			31. Date filed (Month, Day, Year)	1 1	∖ ○ øǧistrar's Signa	6821	120	stus	toun	16	B	ald N	0	
	Sta Registr		MAY 0	3 2007	ogistial s Signa	A A	me							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician ATRICK 2158 2007 24 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Howard Country Howard Genera COlumbia If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 293.64.2196 10 M 2□F 49 Months Yrs. Director December 31, 1957 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Show r 28a-f show notified at 10d. Inside City Limits Maryland Howard Funeral Director Columbia 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d other than "natural", or items 23a or a event, the Medical Examiner must be n 7261 Eden Brook Drive 21046 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 【 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □ Yes 2 No þ Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene, marked other than Elementary/Secondary (0-12) College (1-4or 5+) disabled none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe Eugene C. Brown of Health and Menta item 27 Is marked r other traumatic ev Alyce S. Jeffery 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trau 2902 Fox Fire Court Ellicott City, Maryland 21042 Mr. Jeff Brown Brother Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 04/30/07 Baltimore, MD **Bayview Crematory** signature of Fareral Service Licencee 22. Name and Address of Facility undieller Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 of or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease, shock, or heart failure. L Approximate Interval Between Onset and Death m ediate Cause (Final di ease or condition sulting in death) Physician ARDIOPULMONAR /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): ox **68760**, **E** and Due to (or as a consequence of): Box 68760, physician s the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Vear 5 Other (specify) or Vital Records, P.O. the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should 1 🗌 Yes No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No has autopsy certificate rmea? 2**X** No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of Injury After t 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division or Attending 5 ☐ Pending investigation (Month, Day Year) Natural Injury death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8835 100 PKY, FLITEN, UTTO MI Columbia James Day, Year, 31. Date filed (Month Year) 32. Registrar's Signature State 2007

DHMH 17 Rev 1/2001

Registrar

CRASS

			1 - State of Maryland / Dep. State of Maryland / Dep. Ce	artment of Health and M rtificate of Death	Mental Hygie	71111	14247
	Physici		Decedent's Name (First, Middle, Last) Cooper Buck Brigh	ıt	100	Day Year	3. Time of Death 2:15 p. M
in the	/Medio Examir		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	iviay	1, 2007 4c. County of Death	2.10 p.
*	Exami	iei	Charlotte Hall Veterans Nursing Home		lotte Hall	,	alvert
	Funeral			Il Under 1 Year Il Under 24 Hrs.			lace (State or Foreign
	Director		5. Social Security Number 6. Sex 12 Age (In yrs. last birthday) 185-05-3843 7. Age (In yrs. last birthday) 98 Yrs.	Months Days Hours Min.	January 31,	1909 N	lew Jersey
	D		Usual Residence of Decedent				
	ehow		10a. State 10b. County 10c. City, Town or Le	ocation		1	Od. Inside City Limits
	Sa-1 e	cto	Maryland Dorchester	Cambridge			1 ☐ Yes 2 ☑ No
	ih th	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of Whal Coun	try?
	23a		880 Hills Point Rd.	21613		U.S	
	filed within 72 hours after death with the Maryland Hygiene. uther than "naturel", or Iteme 23a or 28s-1 ehow int, the Mudical Examiner must be notified at	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armyed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	or l	by Fi	1 Never Married 2 Married 1 Yes 2 No 1942 1942 1942 1943 1944 1944 1944 1944 1944 1944 1944	1 ☐ Yes 2 No Specify:		Specify:	White
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2	be filed withintal Hygiene. Id other than		17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	den Sumame)	
an	a la p	Be c				lla F. Buck	
Maryland 21215-0036	s 1 and 2 should be filed w f Health and Mental Hygie Item 27 Is marked other t other treumatic event, ID	2	William Henry Bright 19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ing Address (Street and Number or Run			Code)
S	od 2 s lith ar 27 ls treu			880 Hills Point Rd. Cambrid			
ā,	ges 1 and 2 it of Health if Item 27 I or other tre	-	20a Method of Disposition 20b. Place of Dispo	osition (Name of		Location - City or To	wn, State
Baltimore,	0 0		1 □ Burial 2 Scremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify).	matory or other place)	10212007	Poltimo	ro MD
臣	permit. Pag Department Important: I any Injury c		Fay	view Crematory 2. Name and Address of Facility	/03/2007	Baltimo	re, MD
Ba	permit. Pag Department Important; I any Injury o		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	The second community and a second community	e. P.A.		
	-		23a Part 1. Enter the discusse, or complications that caused the death. Do not en	3871 Old Columbia ter the mode of dving, such as cardiac	Pike Ellicett C	ity, MD 21043	Approximate
-			shock, or heert failure. List only one cause on each line. Immediate Cause (Final				Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. a. a. a. a. a. a. a. a. a. a. a. a. a	r's Der	nentic	a	
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		-	Sequentially list conditions, if any leading to immediate	mytery asc	ase		
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Box	atter for u	cian	in the past 12 months?	□Ectopic pregnancy □ Other (specify)			Day Year
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P.0	res that igned by be deta		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacc	co use contribute to th	e cause of death?
ds	uires sign d be	d by			1 ☐ Yes	2 No 3 Prob	ably 4 Unknown
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36	has ye 2	d u			24a. Was an autopsy performed	prior to cor	psy lindings available apletion of cause of
<u>=</u>	n: The licete har, page				1□ Yes 2	No 1 ☐ Yes	2 No
ξ	ysicien: Th is certificete director, pag	Be	25. Was case relerred to medical examiner?	Othor	h (Check only one)		
ō	Phys this ral dia	၉	1 Tes 2 INO 1 Inpatient 2 EH/Outpatie	nt 3 DOA 4 Nursing Ho	ome 5 Residence 28d. Describe how i	6 Other (Specify)
n	ding F	- Fo	1 Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at Work? M 1 □ Yes 2 □ No	200. Describe now i	niary occurred	
Si	Attendii death. ctor: A y the fu	ica	3 Suicide 6 Could not be		281 Location /Stree	t and Number or Rura	l Route Number
Division of Vital Records,	l or Atten after deat Director: I in by the	Certification:	4 Homicide determined building, etc. (Specify)	icut, lactory, onice	City or Town, S	tate)	TIODIO TIDILI
_	To the Hospital or Attending Physicien: The law requires that the deeth certific within 24 hours after death. To the Funaral Director: After this certificete has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier Certifying Physician: To the best of my knowledge, deal	th occurred at the time, date and place	and due to the cause	a(s) and manner as st	ated
	24 h 24 h Fur etely	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occur	red at the time, date	and place, and due to	the cause(s)
	o the	Me	29b. Signature arrestitle of certifier	29c. License number	29d.	Date signed (Month, i	Day, Year)
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	_		30. Name and address of person who completed cause of death (Ijem 23a) (Type,	Print) -		1112	00 /
	5		30. Name and address of person who completed cause of each (Item 23a) (Type	05 PrinceF	vodvic	6 MAD	20675
	Sta	ato	31. Date liled (Mogth, Day, Year) 32. Registrar's Signature	JO / PIPICE	· Carro	1,100	- 0010
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend Item 23a per dr., g867,05/03/07debrificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Gratton M. Boston 8:55 A M ADIPI 2007 22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltemore Ungressity of Maryland Medical Conter NA 8. Date of Birth (Month, Day, 12-26 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral 1**2 M 2 □ F Months Days Hours Min 506-68-5884 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. Count or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. "Inatural", or Items 23a or 28a-f show Importain: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Director ermantowr 10e. Street and Num 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ lac 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) TOO 17. Father's Name (First, Middle, Last) Be Bostor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) a. Informant's Name/Relationship (Type. 19118 Willow Germantown, and 20874 20b. Place of Disposition (Name of cemetery, crematery or other place, 20a. Method of Disposition 1 Bunial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funesal Service Licensee mD 23a. Part1. Enter be disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive heart tailore -/Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ned by the a ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 √ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After 1 Natural 5 ☐ Pending investigation 1 Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Funeral 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I the within 7 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MA 17400 ADIS1 22, 2007 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 0 Cabassa, MD 22 SouTh Greene Sto Baltemore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

3 2007

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	s. Cunn		1- For State Registrar	e of Maryland /		rtment o tificate o		d Menta		Reg.	No. 20	10	7 11,24
	Physici I Exami		1. Decedent's Name (First, Middle, L James G. Cunning						2. Date of Month April		ay Year 07		3. Time of Death 1945 hrs
Q. Street			4a. Facility Name (if not institution, of 2157 Harman Avenue	give street and number)			4b. City, Town, or Baltimore	Location of E			4c. County o	f Death	
	uneral irector		5. Social Security Number 6.	Sex 7. Age	(In yrs. Ia 8 .6	ast birthday) Yr:	If Under 1 Yea			of Birth(1	Foreign	hplace (State or number) MD
	any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loca	tion						10d. Inside City Limits
	ě .,	ō	MD N/A		Balt	imore							1 XYes 2 No
, i	를 틀릴 급 215/ Harman Avenue 21230 U.S.A.								Citizen of What	at Coun	try?		
	after death wi al", or items ner must be	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorc	ed Armed Forces?	No	S. 13. W	as Decedent of His res, specify Cubar Yes 2 X No	n, Mexican, Pi	? (Specify Yes uerto Rican, et	or N o- c.)	14. Race White	etc.	can Indian, Black,
336	tnin /2 nours : ne. • than "natur? • di al Exami	Completed b	15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade com College (1-4 or 5	pleted)		nt's Usual Occupa nost of working life Man				Sb. Kind of Bus Plumbin		ndustry
21215-0036	oud be filed within 72 hou d Mental Hygiene. s marked other than "nat it event, the Medical Exa	Be	17. Father's Name (First, Middle, La George Cunningha	m				Bessi	Name (First, Mi e Duke				
MD 2	rages I and 2 should be in ment of Health and Mental lant: If item 27 is marked or other traumatic event,	2	19a. Informant's Name/Relationship James G. Cunning 20a. Method of Disposition	ham, Jr./So		4828		Cannii	ng Hous	e Rd	. Madis	son	MD 21648
Baltimore,	perror. rages 1 and 2 shour Department of Health and M Important: If item 27 is n injury or other traumatic		1 X Burial 2 Cremation 3 4 Donation 5 Other Special		Lou	don Pat	ther place) Ck Cemete	ery 5.	Date -1-2007			ore,	Maryland
Ba	Depar Impo injur		21. Signatur Funeral Service Lic	em			Name and Address						of Lansdown 21227
/N	ysician Medical aminer		23a. Part I. Enter the disease, or cor failure. List only one cause on Immediate Cause (Final disease					such as card	liac or respirate	ory arrest	, shock, or hea	rt	Approximate Interval Between Onset and Death
			or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.										
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.09	s be exectors a vician a burial - 1	Medical	UNPENDED	AMENDED									
Sion of Vital Records, P.O. Box 68760,	e deam ceruicate be executed the attending physician and ed for use as the burial - transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 Live birth 4 Pregnant at	, ,	2 Fe	etal death 3 ther (Specify)	Ectopic pr	regnancy		23d. Date of o		ay Ye ar
P.O. B.	d by the		Part II. Other significant condition	9 Unknown	but not re	esulting in the	underlying cause	given in Part I	l. 23e.	. Did toba	cco use contrit	oute to t	he cause of death?
Js, P	w requires that the is been signed by a should be detache	ted by							- 11	✓ Yes Was an			ably 4 Unknown
Division of Vital Records,	ne raw re te has be ige 2 sho	Completed							_ _	autopsy performe Yes 2	pr ed? de	ior to co	ompletion of cause of
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of Vi	After this funeral dir	의	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie 28a. Date of Inju (Month, Day, Ye		ER/Outpatien 28b. Time of		Other N	lursing Home 28d. Des		sidence 6		Scene
ion	death ttor: A y the fur	ation	1 Natural 5 Pending Accident Investiga		ear)		1 ,	Yes 2 No	0				
Divis	ours after deral Direction by	Certification:	3 Suicide 6 Could no determin	ot be	ury - At ho	me, farm, stre	et, factory, office t	uilding, etc.		ation (Stre		r or Rur	al Route Number, City
H 244	To the Funeral Director: Completely filled in by the fi	Medical C	29a. Certifier 1 Certifying Phys	ician: To the best of my er:On the basis of exan and manner stated.									
•	3 E 3	Me	29b. Signature and thile of certifier	4/1/			29c. Licens O.C.			- 1	9d. Date signe	,	th, Day, Year)
	6×1		30. Name and address of person who Susan Hogan MD. As	o completed cause of desistant Medical Ex			nn Street, Balt		21201				
		ate	31. Date filed (Month, Day, Year)	32 Registrar	's Signatu	re /	di)						
	Regis	ueli	MAY 0 3 2	007 Malera	1 18	16 143	40						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Merritt R. Clifton Jr APRI 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Prince George's Lanham 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Maryland 216-32-2068 73 1934 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show aminer must be notified at 1 ☐ Yes 2∏ No MD Prince George's New Carrollton Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8322 Nicholson Street 20784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. event, the Medical Examiner 1 XYes 2 No
If Yes, Give
Year or Dates: \$\frac{1}{55-57}\$ 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 2 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) renovator housing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be fi Is marked Merritt R. Clifton Sr Mary Clarke and 2 should P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 Janet Clifton/spouse 8322 Nicholson Street New Carrollton, MD 20784 more, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Important: If It any injury or o once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Balti State Anatomy Board 655 W. Baltimore Street 21. Signature of Rineral Trylce Licensee Rone 1d S. Wade, Director Baltimore, MD 21201 23a. Part1. Enter the disease, of complications to shock, or heart failure. List only one cause ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final uncrean **Physician** disease or condition resulting in death) /Medical to (or as a consequence of) Examiner INC Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 3 Ectopic pregnancy Dav 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 4th Nown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 I I I patient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 🗌 Yes 2 No iours after death.

neral Director: A
filled in by the fu 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

within 24 hours a To the Funeral I

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ecil

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. George

MAY 0 3 2007

7525 Greenway

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Center Dr., Suito 113, Greenbelt, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 18, Penny Dehoff 2007 3:45 pm April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Univ. of Maryland Medical System Baltimore N/AIf Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) MAY 7 1953 Birthplace (State or Foreign Country) 1 □ M 2 🕅 F Months Days Hours Min. 217-62-9109 53 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8212 Anglers Edge Court 21060 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 TNo Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Letcher Chapman Hazel Edwina Collins Collins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. DeHoff, Jr. - husband 8212 Anglers Edge Court, Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 4/20/2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee H. Williams 22 Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septic Shock Due to (or as a consequence of): disease or condition resulting in death) Cardiopulmonary Collapse Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Bacteremia Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Feta! death 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed? 1□ Y**X**S 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u>

72 hours after

filed withir Hygiene.

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permit. Pages 1 and 2
Department of Health as
Important: If item 27 is any injury or any

Baltimore, Maryland 21215-0036

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Certification:

attending physician and for use as the burial-tran ed by the g signed to peen has page 2 certificate this

P.O. Box 68760,

Records,

Division or Vital

certificate be After t Hospital or Attending death. Director: To the within 24 hours a...
To the Funeral Direct

Medical 9 State Registrar

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🖾 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner' Hospital: 1 ☐ In atient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ NX 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

29c. License number

D58455

29d. Date signed (Month, Day, Year)

April 26, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. James S. Gammie, 22 S. Greene Street, Baltimore, Maryland 21201

31. Date filed (Month)

(Check only one)

29b. Signature and title of certifier

32. Registrar's Signature

Please Type or Print in Black indelible link. Ensure All Copies Are Legible. UNKUNK Ronald D. Daniels State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day April 29, 2007 Year Ronald D. Daniels 0150 hrs **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 4711 1/2 Harford Road Baltimore 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Country) MD Days Hours Min Months Director 1^X M 2 F 08/02/1971 217-84-4772 35 Yrs Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County any 1 X Yes 2 No Baltimore 28a-f show MD or items 23a or 28a-f shormust be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21206 4334 Greenhill Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) after death with 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc Armed Forces? 1 Never Married 2 XXMarried African American 2X No Yes Yes 2 X No specify Specify f Yes, Give Yea 3 Widowed 4 Divorced Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. I fant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner. ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 custodian 9 unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Calvin Lee Walker Mary Ann Daniels 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2201 Clifton Avenue; Baltimore, Maryland 21216 Angela Daniels / Wife 20c. Location - City or Town, State Baltimore, N permit. Pages 1 and Department of Healt Important: If item injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 05/05/2007 Baltimore, Maryland Mount Zion Cemetery Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Two Gunshot Wounds of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -UNPENDED AMENDED Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ś 1 Yes 2 ✓ No 3 Probably 4 Unknown Division of Vital Records, P. Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✔ Yes 2 1 🗸 Yes : No 2 No this certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi 25. Was case referred to medical Be examiner? Other₄ Hospital: Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 DOA ဥ 1 🗸 Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Apr 29, 2007 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Medical Certification: Subject shot 0138 hrs ___ Natural 1 Yes 2 ✔ No Pending 2 ___ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 Could not be ___ Suicide or Town, State) 4711 1/2 Harford Road, Baltimore, MD determined (Specify) Sidewalk 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. April 29, 2007 30. Name and address of person who completed cause of death (Item 23a) 3 Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Mary G. Ripple MD. 32. Regiatrar's Signature 31. Date filed (Month, Day, Year) State MAY Registrar

ORIGINAL

07-03257

Maryland 21215-0036 mil dred

P.O. Box 68760, Division or Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** April Mildred Dollar 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner baRLRS enter ivista 8. Date of Birth (Month, Day, Year) Social Security Number Funeral Days Months 1 □ M 2 🕱 F OK Director 442-26-0285 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County the Medical Examiner must be notified at 1 Tyes 2 □ No Director LaPlata MD Charles 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a 1372 Redwood Circle 20646 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married is marked other than "natural", or 1 ☐ Yes 2 🔼 No White Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Department of Health and Meni Important: If item 27 is marker any injury or other traumatic e ဂ္ဂ Cleo Phillips Bill Birchfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Samuel W. Dollar/Son 1372 Redwood Circle, LaPlata, MD 20646 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of h 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Park May 2, 2007 Enid, Oklahoma 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ladusau-Evans Funeral Home 21. Signature of Funeral Service Licensee CH 2800 N Van Buren St., Enid, OK Approximate Interval Between Onset and Death 23a Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SDIRALT Physician /Medical Due to (or as deconsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Anasarca burial-tran Due to (or as a consequence of): attending physician for use as the burial poalbuminemia pe Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Month Dav Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9☐Unknown 9 ☐ Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed? 1 Yes 2 No certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

Ieral Director: A
filled in by the fu 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 28/0 Suite 103 Waldorf 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11637 TERRACE DR.

State Registrar

DHMH 17 Rev 1/2001

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	1	For S' State Registrar	tate of Mary		ertificate of			giene _, Reg. No. (2007	14254
Physician		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death
/Medica	4	Marian A. Dittm. 4a. Facility Name (If not institution, give street			4b. City, Town, o	r Location of Death	May	1,	2007 ounty of Deat	8:27 A M
Examine		Gilchrist Center	Í		Tow	son			Baltin	nore
Funeral		5. Social Security Number 6. Sex		n yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	Co	hplace (State or Foreign untry)
Director	-	245-62-1316 Usual Residence of Decedent	66	Yrs.			Dec. 1	9, 19	40 No:	rth Carolina
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eath v	Lanera	3861 Beatty Road 11. Marital Status	Nas Decedent Eve	er in U.S. 13	. Was Decedent of H		pecify Yes or No)- 14	U. S. 4. Race - Ame	
	ny rull	1 □ Never Married 2 💢 Married	Armed Forces? I	5.5.	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🎇 No	an, Mexican, Puert Specify:	o Rican, etc.)		Black, White Specify: Wh	e, etc.
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permil Depar Impor any ir	ł	Mille			9705 Belai					
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Physician	1	Immediate Cause (Final disease or condition	Diabe	tic 1	Sephrops	1124				Onset and Death Y Tar 3
/ /Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):	9 6	1				/
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or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.	- At home, farm, s (Specify)	street, factory, office		28f. Location (City or To	Street and wn, State)	Number or Ri	ural Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier (Check only (Ch	On the basis of e	xamination and/or						
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10		30. Name and address of person who comp	leted cause of dea	th (Item 23a) (Typ		(i (+ F	NUWN	403	11 601	<u>-</u>
l -		AMON J. CHARM		6701 N	Chirt	-0 31)	- JU/V	vi) C	10%	
State Registra		31. Date filed (Month, Day, Year)	32 Registrar's	Signature	ande					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene UU 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4a. Facility Name (If not institution, give street and number) 8 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Mary Med Center band Dal timore nivesit If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🛱 F 218-07-2643 Yrs. Feb 2, Director 93 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow treumatic event, the Medical Examiner must be notified at MD Baltimore YOYes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 814 Whitmore Avenue or items 23a 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) childrens aide school system 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Chase Anna Pauline Oliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hazel Monk-Montgomery/daughter 2221 Font Hill Court Langhorne, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Licensee Wade State Anatomy Board 655 W. Baltimore Street Director m. Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** (3 Courd nknown /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed signed by the ettending physicien and I be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No within 24 hours efter death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, paga 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1□ Yes To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No 1 / Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital within 24 hours e 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) B16629 MD30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HIROKO BECK, MO S. GREENE ST. BALTIMORE, MD 21201 22 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 200 Jonathan Dixon 6:00AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea **Examiner** harlestown onsville MOVE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months 1⊠M 2□F Yrs 219-07-3088 85 24, Director 1921 New Jersey Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic evant, the Medical Examinar must be notified at Director MD Baltimore 1 ☐ Yes 2√2 No Catonsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? with or ftems 23a or 719 Maiden Choice Lane BR641 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à Specify: white 3 Widowed 4 Divorced "naturaf" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygiens Important: If item 27 is marked other the any injury or other traumatic avent salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jonathan Dixon Sr 0 Martha Crowell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Nussbaum/step daughter 3441 Plantation Grove Colorado Springs, CO 80920 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) * 4 X Donation 5 ☐ Other (Specify) 21. Signature of Eune I Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MĎ 21201 23a. Pan1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** ta disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 1 ☐ Yes 2 ☐ No detached 9□ Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, old be à 2 100 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autopsy certificate 2 No 1 ☐ Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 10 1 □ Yes 2 □ Ne 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide within 24 hours a 1 dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifiei (Check only one) and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 4700 who completed cause of death (Item 23a) (Type, Print) Maiden 711

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MAY 0 3 2007

2. Registrar's Signature

Physician

/Medical

Examiner

Funeral

Director

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

212-22-5122

Usual Residence of Decedent

Raymond J. Deigert

4a. Facility Name (If not institution, give street and number)

1**½** M 2□F

Johns Hopkins Bayview

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

7. Age (In yrs. last birthday)

80

Certificate of Death

Baltimore If Under 1 Year | If Under 24 Hrs.

Days

4b. City, Town, or Location of Death

City

Reg. No.

Day

25

2007

4c. County of Death

3. Time of Death

Birthplace (State or Foreign Country)
 MD

MD

2. Date of Death

Month

APRIL

8. Date of Birth

1(Month 2 1 - 1 9 2 6

			1- For State of Maryland /	Department of Health and I	Mental Hygien	2007 14233
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last) St. Christinam. Daily, R.S., 4a. Facility Name (If not institution, give street and number)	M. 4b. City, Town, or Location of Death	MAY	Oay Year 3. Time of Death 2007 2:08PM
	Funeral Director	ler	5. Social Security Number 6. Sex 1 M 2 S F 7. Age (In yrs. last)	Baltimore		Baltimore 8 Rightholage (State or Foreign
	the Maryland 28a-f ehow	Director	Usuel Residence of Decedent 10a. State 10b. County 10c. City, To	timore	10a. C	10d. Inside City Limits 1 □ Yes 2및 No Citizen of What Country?
36	d within 72 hours after death with the Maryland Jiene. r than "natural", or iteme 23a or 28a-f ehow The Medical Examinar must be incilited at	by Funeral Di	6806 Bellona Avenue 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	2 1 2 1 2 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	U S	
21215-0036	D 0 = =	Completed I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4or 5+)	king	Kind of Business/Industry Medical	
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	Physician /Medical Examiner	her	23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	nonia 1 Cancer, metasta		Approximate Interval Between Onset and Death
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.O. Box 68	death certif e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death			23d. Date of delivery Month Day Year
ords, P	The law requires that the de ste hes been signed by the a bage 2 should be detached f	þ	Part II. Other significant conditions contributing to death but not resulting HyperHension	g in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Vital Records,		Be Completed	25. Was case referred to medical	26. Place of Dec	24a. Was an autopsy performed? 1 Yes 2 X	
Division of V	ding Phys After this funeral dir	Certification; To E	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	b. Time of lnjury at Work? M 1 Yes 2 No	28d. Describe how in	jury occurred
Div	To the Hospital or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the		4 Homicide determined building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowled	dge, death occurred at the time, date and place	City or Town, Sta	u(s) and manner as stated
	To the He within 24 To the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated. 29b Signature and tale of certifier	29c. Ucense number	(29d.)	Date signed (Month, Dey, Year)
	3		(30.) Name and address of person who completed cause of death (Item 23:	St Paul Place !	3 altimore	May, 1, 2007
*	Sta Regist		31. Date filed (Month, Day, Year) MAY 0 3 2007	South The P	,	a local

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 10:30 PM AUDREY ANE 04 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WILLIAMSPORT WASHINGTON HOMENWOOD CENTE RETIREMENT If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🛱 F 83 Director 187-14-6460 July 29, 1923 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tier 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Washington 1 ☐ Yes 2√ No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 525 N. Locust Street 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white Be Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housewife own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Ralph Reedy Florence Evelyn Ward 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Cline/daughter 198 Merrimack Drive Falling Waters, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 4 Donation 5 Other (Specify) 21. Signature of Runeral Service Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street tim Baltimore, MD 21201 23a. Part . Enter the disease, /r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 9 415 Lung cancer /Medical Due to (or as nsequence of): Examiner tibrillat Sequentially list conditions, any, and the Lamburg Lamburg Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 N No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. 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Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a, Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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M, O

13424

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

DHMH 17 Rev 1/2001

ORIGINAL

PENNSYLVANIA

29c. License number

D47234

AVE

29d. Date signed (Month, Day, Year)

HAGERSTOWN

07-03213	
Diane Eidinger	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year 4.0041	lall	e Eloli	igei		For State of Maryland / Department of Health and Mental Hy		. No.	7 1426
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1		of Hea	If iter		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 Cremation 3 Removal from State Chesapeake Crem. 05.		•	
Physician Medical Geniner 23a. Ph. Enter the disease, or complications that caused the death. Do not enter the most of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Ph. Enter the disease, or complications that caused the death. Do not enter the most of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Ph. Enter the disease, or complications that caused the death. Do not enter the most of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Ph. Enter the disease, or complications that caused the death. Do not enter the death of the cause of the death line. 25b. Turned of the line of the cause of death? 25c. What cause referred to medical part of the cause of death of the cause of death? 25c. What cause referred to medical part of the cause of t		It. Pag	y or o		4 Donation 5 Other Specify:			
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29b. Signature/and/fulle of certifier O.C.M.E. April 28, 2007 30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant/Medical Examiner 111 Penn Street, Baltimore, MD 21201		execut	ian and ial - tra			porMF a97	0 8/6/07 TT	-
29b. Signature/and/fulle of certifier O.C.M.E. April 28, 2007 30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant/Medical Examiner 111 Penn Street, Baltimore, MD 21201		760, cate be	physici the buri	/Med	#17, perrn, goor. 3/3/0/11// #234, rii, 2041, IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	i y
29b. Signature/and/fulle of certifier O.C.M.E. April 28, 2007 30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant/Medical Examiner 111 Penn Street, Baltimore, MD 21201		certifi	ending use as	<u> </u>	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	ancy	Month	Day Year
29b. Signature/and/fulle of certifier O.C.M.E. April 28, 2007 30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant/Medical Examiner 111 Penn Street, Baltimore, MD 21201		Boy ne death	the att	hysi	a Divioni	Dog Did to	no and upp contribute to	the sauce of death?
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30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		T ₀	To	Mec	29b. Signature and fuller of certifier 29c. License number			onth, Day, Year)
Susan Hogan IVID. Assistant/Medical Examiner 111 Perin Street, Bartimore, IVID 21201			1 pert				April 28, 2007	
Los Physics Country of the Marie Country of the Mar		10	71			1201		
Peristran			S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

State of Maryland / Department of Health and Mental Hygiene) For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician Bonnie Lee Elliott** 3:40 а.т. м April 29, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Catonsville 2530 Old Frederick Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month Days Hours Min. March 17, 1949 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months 1 M 2 F Baltimore, Maryland 58 Director 212.56.6327 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a State ? Is marked other than "natural", or Items 23s or 28s-1 show traumatic event, the Madical Exerciper invat be notified at 1 ☐ Yes 2 1 No Directo Catonsville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 U.S.A 2530 Old Frederick Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White δ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) public school system al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) cafeteria manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental Evelyn Eyler Melvin Danson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2530 Old Frederick Road Catonsville, Maryland 21228 Mr. Warren Myers Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 0 <u>=</u> 1 Burial 2 Cremation 3 Removal from State 5 permit. Page Department of Important: If any injury or once. 05/02/2007 Ellicott City, MD 4 ☐Donation 5 ☐ Other (Specify) St. John's Cemetery e of Fundal Service Licen 21. Signaty 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 imalalla MOOS 35 Part1. Enter the disease, hock, or heart failure. of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Onset and Death nnediate Cause (Final sease or condition sulting in death) CANCER METASTATIC **Physician** LUNG YEAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires thet the death certificate be executed as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physicien by Physician/Medical ettending 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Year Day 1 ☐ Yes 2 No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Š Signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 8 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Director: After this certific in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNatural 1 Yes 2 No death. 2 Accident Director: 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D16354 4/30/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 CATON AVE BALTIMORE MD ST AGNES .W. COLE 900 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Herbert Raymond Gately 4c. County of Death 4a. Facility Name (If not institution, give street and number) aiku 8. Date of Birth (Month, Day, Year) Social Security Numbe If Under 1 Birthplace (State or Foreign Country) Months Davs Hours 1**X** M 2□ F 213-30-2728 Jan. 10, 1932 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 No Director N/A Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2609 Putty Hill Ave., Apt D 21234 U. S. A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 B G & E Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Herbert W. Gately Marie M. Kuzak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16923 Flickerwood Road, Parkton, Maryland 21120 Frederick Gunther(nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/03/2007 Baltimore, Maryland Most Holy Redeemer 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Road, Baltimore, Maryalnd 21236 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Tue to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deatle? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 2 DNo 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

burial-transit and Box 68760, physician a the burial pe as attending properties for use as ed by the a detached f P.0. signed b Division or Vital Records, been signature certificate has this funeral After t death. l or Attend after death. Director: / filled in by the Hospital 24 hours a To the P within 24 To the P

completely

Physician

Examine

Funeral

Director

28a-f show

ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", any Injury or other traumatic assets.

Physician /Medical

Examiner

/Medical

7

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

and manner stated.

29c. License number D0065490

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of pers who completed cause of death (tem 23a) (Type, Print)

31. Date filed (Month, Day, Registrar's Signature MAY 0 3 2007

07-03118 Roland Green Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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naria Oreen		- For State	Certific	ate of Death		Reg. N	lo.	0 / 1 1 1 0
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)			Date of Death Month Da	y Year	3. Time of Death 0000 hrs
edical Exami	ner	Roland _	Greek	Λ		April 23, 2007	,	
		4a. Facility Name (if not institution, give	street and number)	4b. City, Town, or Los Baltimore	cation of Death		4c. County of Deat	"
		Union Memorial Hospital	7. Age (In yrs. last birt		If Under 24Hrs.	B. Date of Birth(N	IM/DD/YYYY) 9. Bi	irthplace (State or
Funeral		5. Social Security Number 6. Se	,	Months Days	Hours Min.	,	950 Forei	irthplace (State or ign 4 cmd
Director		W11-70 4-1101	M 2 F 57	Yrs.		7-2-1	700	11101
any	- }	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
*		14.1 01/1	Barre	timone				1 ¥es 2 No
E Y S ne Maryland or 28a-f show fied at once.	용	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	untry?
of 842 with the Maryland ms 23a or 28a-f sho be notified at once.	ä	2832 Oakfo	rd Also	212	15		U.J.7	A
with th	ā	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispa If Yes, specify Cuban, M	anic Origin? (Spec	cify Yes or No- can, etc.)	14. Race - Ame White, etc.	erican Indian, Black,
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygies with a Tris marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Funeral Director	1 Never Married 2 Married	1 Yes 2 No	,			Specify: B	ack
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hours natur		15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working life. D	OO NOT use retired	d)		
36 in 72 han "	Completed	Elementary/Secondary (0-12)	College (1 4 of 5)	Carpente	~		Constru	ection
5-0036 iled within 7 Hygiene. I other than	ĕ	17. Father's Name (First, Middle, Last)	18	3.Mother's Name (F	First, Middle, Maid	den Surname)	
215 be file ntal Hy rked o	Be	Lorman G	roen		Eva (arey		
21. ould b d Mer s mar	ို	19a. Informant's Name/Relationship (1 1	9b. Mailing Address (Street	. /			ite, Zip Code)
MD d 2 sho Ith and n 27 is		Barbara Green	SISTEY O	e of Disposition (Name of ceme		Date 2	hester la.	or Town, State
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Heath and Monta Hygiene I ant: I fiem 27 is marked other than or other traumatic event, the Medical or other traumatic event, the Medical		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State crema	atory or other place)		4	211/	1.
limore, MD 21215-003 Pages 1 and 2 should be filed within and of Health and Mental Hygiene. Antait: If tiem 27 is marked other it or other traumatic event, the Med	W	4 Donation 5 Other Specific		in mount Cremate	of cility	F-20011	Ball. le	04
Baltimore, permit. Pages I ai Department of He Important: If ite	Ų	21. Signature of Funeral Service Live	asee	22. Name and Address) guglass	Bulka	LEVUICE	7.9.
		23a. Part I. Enter the disease, or com	plication at caused the death. Do	not enter the mode of dying, s	such as cardiac or	respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
Physician Medical	11 3	failure. List only one cause on e	each line. Alcohol and narcotic					Death
aminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	e intoxication				
		Sequentially list conditions,)					
	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):					
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0, be ex sician burial	Medical	X UNPENDED	#23a,27-28a-f, per)7 TT		23d. Date of deliv	very
8760 ificate b	N S	23b. Was decedent pregnant in the	1 Live birth	2 Fetal death 3	Ectopic pregnar	псу	Month	Day Year
Box 687 e death certific the attending I ed for use as the	sician	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of death	5 Other (Specify)				
Bo ne deal	اع ا	Post II. Other cipelficant condition	g Unknown s contributing to death but not result	ting in the underlying cause g	iven in Part I.	23e. Did tob	acco use contribute	e to the cause of death?
that the ned by detach	ا ۾	Part II. Other significant conditions	Contributing to death but not result	ting in the theorying seems y		1 Yes	2 No 3	Probably 4 🗸 Unknown
IS, P quires I		/ 				24a. Was ar		e autopsy findings available to completion of cause of
cords, law requir has been s	흩	·				autopsy	ned? death	h?
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Division of Vital Records, P.O. In or Attending Physician: The law requires that it is after death. In all Director: After this certificate has been signed by all nin by the fineral director, page 2 should be deated.	å	examiner?	Hospital: 1 Inpatient 2 ✔ ER		- ·		tesidence 6 C	Other:
of V ing Phys After thi	2	1 ✓ Yes 2 No 27. Manner of Death			ry at Work?	28d. Describe ho	ow injury occurred	
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risic r Atte ter des irecto	fica	2 Accident Investig 3 Suicide 6 X Could n	anon Diese of Injury At home	e, farm, street, factory, office b	uilding, etc.	28f. Location (St or Town, Sta		r Rural Route Number, City
Division of the price of the pr	Certification:	4 Homicide determi	ned (Specify) found at	residence			Ave. Baltir	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The the this been signed by the attending physician and To the Purneal Director: After this certificate has been signed by the attending physician and compleably filled in which fineral director, page 2 should be detached for use as the burial - trans			sician: To the best of my knowledge, ner: On the basis of examination and/	death occurred at the time, da	ate and place, and . death occurred a	due to the cause at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	one) 2 Medical Examin	and manner stated.	29c. Licens				(Month, Day, Year)
	2	29b. Signature and title of certifier	16: 1	0.C.			April 24, 2007	7
	1	Theodor M.	The will the second of the state of the second	7.				
		30. Name and address of person when Theodore M. King, Jr., M.	no completed cause of death (Item 23 MD. Assistant Medical Exa		reet, Baltimor	e, MD 21201		
	Stat	e 31. Date filed (Month, Day, Year)	Registrar's Signature	1				
Reg			17 Been B.	and the same				
DHMH 17 Rev	/2001	1		ORIGINAL				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2007 Month **Physician** 3:30 PM M Elizabeth Gray 1, /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner 1 Hamill Ct. Apt. 26 Baltimore Baltimore City 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 PA 5. Social Security Number 6. Sex 8. Date of Birth Funeral Months Hours Min 171-22-4690 Days 0870571915 1 M 2 F Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show the Medical Exertinar must be notified at MD 1 Nes 2 No Baltimore City Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 1 Hamill Ct. Apt. 26 21210 USA "natural", or Items 23a within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Own Home 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Alexander McGarvey Agnes Moore McCahan 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or other traum Margaret Rawle/Daughter 1 Hamill Ct. Apt. 26 Baltimore, MD 21210 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition May 3 cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Beltsville, Maryland Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²²Cremation and Funeral Alternatives PPIGIA Sue Rolle 8717 Green Pastures Drive Baltimore, Maryland 23a. Part1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LOMA /Medical s a consequence of) Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) the attending physician Physician/Medical the th IF FEMALE use 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 99 1 🗌 Yes 2 No 3 Probably 4 Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate Was lase referred to medical examiner? 2 NO 1 Tyes Hospital or Attending Physician: 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. М 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by hours after 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

|Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 29c. License number 0 14 of death (Item 28a) (Type, Print) who completed call Name and address of person Alicia A. Co.
31. Date filed (Month, Day, Year) Registrar's Signature State 03 2007

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - State Registrar	State of Maryla		artment of H			giene 007	14265
			Decedent's Name (First, Middle, Last,)				2. Date of Dea	th	3. Time of Death
	Physici /Medio		George	Edward	Hawki	ns		April	Day Year 29 2007	9:45P ^M
j	Examir		4a. Facility Name (If not institution, give	street and number)			or Location of Death		4c. County of Dea	
			Holy Cross Hosp			Silver			Montgom	
	Funeral		5. Social Security Number 6. Se	M 2□F	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	y, Year) 9. Bi	rthplace (State or Foreign ountry)
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	yland		10a. State 10b. County D1	00	ity, Town or Lo					10d. Inside City Limits
	Mar e-f-st	ctor	DC of Columb	oia		Washin	ton			1 X Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	log. Citizen of What C	ountry?
	ath w	rail	3245 Massachuset				019		USA	
	er de	une	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	U.S. 13. 1	Was Decedent of I f Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	rs aft	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		1□Yes 2□XNo	Specify:		Specify: B]	ack
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28e-f show he Mudical Exercities mad Le rodified at	ed	15. Decedent's Edu	cation	16a. Deced	ient's Usual Occup	pation		16b. Kind of Business	s/Industry
215	hin 7	Completed	(Specify only highest grad	e completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of world)	king	Federal Bu	reau of
21	or thu	Corr	8th		Proch	<u>urement</u>	Tech		Investigat	ion
pu	be filed within 72 hours after death with the Marylar ital Hygiene. ed other than "natural", or itame 23a or 28e-f show event, the Medical Exercities must be redified at	Be	17. Father's Name (First, Middle, Last)					•	Maiden Sumame)	
Z	Men Marke narke	Ţ	Thomas	Hawkii			Annie	Belle	Burrough	
Maryland	d 2 sh th and 7 is n		19a. Informant's Name/Relationship (7) Anne Jackson	rpe, Print)					r, City or Town, State, Washingtor	,
بة	1 and Healt		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of		· · · · · · · · · · · · · · · · · · ·	20c. Location - City o	
Baltimore,	ages ant of at: If It		1 ☐XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		matory or other pla M. Cemete	1		Henderson	•
Ħ	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, the MDE.		21. Signature of funeral Service Licens						uneral Hor	n _O PΔ
ñ	Department of the service of the ser		11/2.8	K	31	11 Mount	ain Rd. P	asadena	, Md. 2112	2
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	cations that caused the dea						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Sepsis						Onset and Death
7	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):		· · · · · · · · · · · · · · · · · · ·			
	Lammer	L	Sequentially list conditions.	Due to (or as a conse						
	led sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Prostate						
	al-trai	Examiner	that initiated events resulting in death) Last	Due to (or as a conse						
8760,	The law requires that the death certificate be executed ste has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dical F	(1.						
9	tificat ng phy as th	ledi								
Вох	eath certific attending p	an/N	230. Was decedent pregnant	3c. If yes, outcome of pregr 1☐Live birth 2☐Fet		Ectopic pregnance	,		23d. Date of de	· ·
	the at	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at time of 9☐ Unknown		Other (specify)	·		Month	Day Year
P.0	that the de ed by the detached		Part II. Other significant conditions co	atributing to death but not re	culting in the ur	adorhina cauca an	on in Part I	23e Did to	bacco use contribute	o the cause of death?
Records,	signed l	d by			outing in the di	idonying oddoo gn	on an aut.			robably 4 Unknown
50	w require been si should	lete				<u>.</u>		24a. Was a		
Re	he lav	Completed						autops perform	med? death?	utopsy findings available completion of cause of
	en: T tificet tor, pe	Be Co	25. Was case referred to medical				26 Place of Deat	1 X Yes :	2 No 1 Ye	s 2 🕅 No
<u>></u>	Physicien: this certificatal director,	ToB	examiner? 1 ☐ Yes 2 💢 No	lospital: 1 (npatient 2	☐ ER/Outpatien	t 3 DOA Oth	00		ence 6 Other (Sp	ecify)
0	ng Ph ter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injur			ow injury occurred	
Sio	eath. or: Al	atic	2 ☐ Accident investigation				Yes 2 □No			
Division of Vital	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str ify)	eet, factory, office		28f. Location (Si City or Town	treet and Number or F n, State)	lural Route Number,
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page		29a, Certifier 1X X ertifying Phy	sician: To the best of my kn	oudodas dand	a constant and the	mo data and 1	and don't be it		
	24 hc 24 hc Fun etely	Medical	(Check only 2 Medical Exami	ner: On the basis of examin and manner stated.	ation and/or inv	estigation, in my o	me, date and place, ppinion, death occur	red at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	Fo the	Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (Mon	th, Day, Year)
	r- > F 0		1 Kan	la mo		20	056063		5/1/0-	7
	\cap		30. Name and address of person who	empleted cause of death (Ite	m 23a) (Type,					,
	1			1500 Forest		d. Silve	r Spring,	Md. 209	10	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 3 2007	2. Registrar's Sign	ature	in a				
	negisti	uı	WHI V & 200/	LARBORN AS	1000					

DHMH 17 Rev 1/2001

altimore, Maryland 21215-0036	
ermit. Pages 1 and 2 should be filed within 72 hours after death with	h with
epartment of Health and Mental Hygiene.	
nportant: If Item 27 Is marked other than "natural", or items 23a or	23a oi
	44.44

Box 68760, P.O. Division or Vital Records.

Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Wilham. Month Day Year 4-06 PM **Physician** HARRIGAN E Mou 2007 131 /Medical 4c. County of Death Howard 4b. City, Town, or Location of Death Columbia 4a. Facility Name (If not institution, give street and number) Examiner **Howard County General Hospital** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day Year) July 28, 1920 9. Birthplace (State or Foreign County) aryland 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F Months 219-03-5720 Yrs Director Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits show be notifled at 1 □Yes 2No Ellicott City Maryland Howard **Funeral Director** 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21043 4926 Grace Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting **Accounting Supervisor** 18. Mother's Name (First, Middle, Maiden Surname)
Mary Winikal 17. Father's Name (First, Middle, Last) Be George Harrigan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6910 Parchment Rise Columbia, Maryland 21044 19a, Informant's Name/Relationship (Type. Print) Mr. Michael Harrigan Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 05/07/07 1 Buriel 2 Cremation 3 Removal from State Brooklyn, MD Holy Cross Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A 21. Signature of Funeral Sepace Licenses any De g 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RENAL FAILURE This weary /Medical Due to (or as a consequence of): Examiner For westy RESPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner alor Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit BILATERAL TNEUMONIA that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig D, 30469 May 2 NR. 2007 39. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARKWAY: # 308. COLUMBIA: MD-21045 Ve 31. Date filed (Month, Day, Year) MAY 0 3 2007 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O O T

			1 - For State Of Maryland /	Certificate of D			3. No.	14201
	Physici	an	Decedent's Name (First, Middle, Last)	AMES		2. Date of Death Month	Day, Year	3. Time of Death 3: 15 AM
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Li			4c. County of Deat	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last I	birthday) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day, 04 20		hplace (State or Foreign untry)
	밀	tor		own or Location				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
death with the Maryland ma 23a or 28e-f show rmust be notified at		rai Director	10e. Street and Number 5402 Omaha Avenue	10f. Zip Code 2120	06	10	g. Citizen of What Co USA	untry?
2-003p	hin 72 hours after death with the Marylar e. Madical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Given Year or Dates:	13. Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 🖾 No	panic Origin? (Spe Mexican, Puerto i Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
0-01212	within 72 ho lene. rthen "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade	Sa. Decedent's Usual Occupation (Give kind of work done duit life. DO NOT use retired) Homemak	ring most of worki	ng	Own Home	
and	be filed al Hyg d other	Be C	17. Father's Name (First, Middle, Last)	1	8. Mother's Name			
5	d Menid harken	2	Arthur Tyle 19a. Informant's Name/Relationship (Type, Print)	Mailing Address (Street and	Mary	l Pouto Number	City or Tourn State	Zin Codo)
<u>s</u>	nd 2 sl alth an 27 is r r traur		Henry A. James Son	1535 Sheffi			•	
more,	nit. Pages 1 and 2 should artment of Heelth and Mer orient: If Item 27 is marke injury or other traumatic		20a. Method of Disposition 1	of Disposition (Name of tery, crematory or other place) Hop en Of Eterne	De 5-7		oc. Location - City or Finksbur	
Dall	permit. Departm Importe any inju		21. Signature of Funeral Service Licensee	22. Name and Address	of Facility	March F	.H. East	
68/60,	Physician pe executed by Medical Examiner private private private as the burial-transit	ledical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dialoctes Due to (or as a consequence of the consequence	peripheral demia				Approximate Interval Between Interval Between Insert and Death 3 months Actyclic years 1-2 years
O. BOX 6	death certif e attanding d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of del Month	ivery Day Year	
rds, F	The law requires that the site hes been signed by the page 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given	in Part I.		acco use contribute to	the cause of death?
al Record	The lay	Completed				24a. Was an autopsy perform 1 ☐ Yes 2	ed? prior to death?	topsy findings available completion of cause of 2 ☐ No
VItal	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/6	Outpatient 3 DOA Other:	26. Place of Death		ce 6 ⊡Other (Spe	-4.1
lon or	nding Physicien: sth. r: After this certific e funeral director,	-	27. Manner of Death 1. Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	4 Norsing Hor	28d. Describe how		спу)	
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office		28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowled one) Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my opin	nion, death occurre	and due to the cau ed at the time, dat	ise(s) and manner as e and place, and due	s stated. to the cause(s)
	To t To t	≥	> Susan D. Wolfsthal M	D 29c. License n	N D. WEL	1	5 1 20	h, Day, Year)
	8		30. Name and address of person who completed cause of death (Item 23: UNIVERS ITY OF MARLAND; 22	. South GREEN	EST., B	AUTIMOI	2E, MD 2	1201
3	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	hall i	•			

07-03292 Antonio Jackson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

antonio Gaokson	F	Registrar	te of Death		g. No. 2017 14.26
Physician	-	1. Decedent's Name (First, Middle,Last)		Date of Death Month	Day Year
Medical Examin		Antonio Jackson 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of	April 30, 20	4c. County of Death
		St. Agnes Hospital	Baltimore		,
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	•		n(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		219-53-9850 ₁ X _M ₂ F 8	Yrs. Months Days Hours	Min. 01/23/1	L999 Country) md
8	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	Location		10d. Inside City Limits
ow any		MD	Baltimore		1 XYes 2 No
faryland	핡	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
th the Maryland 23a or 28a-f sho notified at once	Director	7104 Boxford Road	211	215	USA
with ms 23s	널	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican,	in? (Specify Yes or No-	
r death or iter must	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No		rderio Ricali, etc.)	African American
hours after 'natural'',	اھ	3 Widowed 4 Divorced If Yes, Give Year or Datas. 15. Decedent's Education (Specify only highest grade completed) 16a. D	1 Yes 2 No specify:	ind of work done	Specify: 16b. Kind of Business/Industry
2 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	uring most of working life. DO NOT u		Tob. Natio of Educations/intensity
036 tthin 7 ne.	ם	2	student		school
215-0036 be filed within 72 ntal Hygiene. 'ked other than '		17. Father's Name (First, Middle, Last)	18.Mother's	s Name (First, Middle, M	laiden Surname)
21215-0036 uld be filed within 7 Mental Hygiente, marked other than	Be l	Antonio Jackson, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Numl	Katrina F	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	۵	l	104 Boxford Road; Ba		
e, N 1 and 1 Health item	-	20a. Method of Disposition 20b. Place of	Disposition (Name of cemetery, ry or other place)	Date	20c. Location - City or Town, State
Baltimore, permit. Pages 1 at Department of He Important: If ite		Tabulal 2 Gremation 3 Removalifor State	nt Zion Cemetery	05/07/2007	Baltimore, Maryland
Baltimo permit. Page Department of Important: injury or oth	h	21. Signature of Funeral Service Licensee	22. Name and Address of Facility	Wylie Funeral	Home, P.A.
		Tuneda Jones	638 North Gilmor S	Street; Baltim	pore, Maryland 21217
Physician M. dical	1	23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.	enter the mode of dying, such as ca	ardiac or respiratory arre	Approximate Interval Between Onset and Death
xaminer	ĺ	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Bouli
	.	Sequentially list conditions, b			
	<u> </u>	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause c.			
d sit	Examine	events resulting in death) Last Due to (or as a consequence of):			
760, icate be executed physician and the burial - transit		d.			
60, ate be e physicial	Medical	AMENDED #23a, 27, perME, g867	, 5/8/ <u>07 TT</u>		23d. Date of delivery
rtifica ing ph		DOLLARS IN THE STATE OF THE STA	Fetal death 3 Ectopic	pregnancy	Month Day Year
Box 687 e death certificate attending ced for use as t	Physician/	4 Pregnant at time of death 5	Other (Specify)		
Vital Records, P.O. Box 687 ysician: The law requires that the death certificals this certificate has been signed by the attending director, page 2 should be detached for use as t		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Pa	rt I. 23e. Did to	bacco use contribute to the cause of death?
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that it is after death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detac	d b			1 Yes	2 No 3 Probably 4 Unknown
rds, requir	Completed			24a. Was a	
eco he faw ate has	티			perfor 1 ✓ Yes 2	med? death?
al Rian: Tian: T	Bec	25. Was case referred to medical	26.Place of Death ((Check only one)	
of Vit ing Physic After this of	힏	1 Yes 2 No Inpatient 2 V ER/Ou			Residence 6 Other:
n of \ding Phy.h.	티	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. T	ime of Injury 28c. Injury at Work'		now injury occurred
Sion Attent	icati	2 Accident Investigation 28e, Place of Injury - At home, far	m, street, factory, office building, etc		Street and Number or Rural Route Number, City
Div Ital or Ital Di	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, St	tate)
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dear			
To the within To the Comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.		curred at the time, date a	
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) May 1, 2007
		30. Name and address of person who completed cause of death (Item 23a)	J.J.IVI.L.		
			Penn Street, Baltimore, MD	21201	
	м				
Regist	_	The second secon	and the same of th		
DHMH 17 Rev 1/20	01	OR	GINAL		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 April 24, **Physician** 2:00 AM M Donald M. Jacobs /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16506 Fairview Road Washington Hagerstown If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, You June 14, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1**7** M 2□ F 1914 West Virginia 92 Director 234-14-5479 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d, Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or iteme 23a or 28a-1 ehov Lry or other treumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 USA 16506 Fairview Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Armed Forces:

1 Xi Yes 2 No
If Yes, Give
Year or Dates: 143-45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white \$ Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 butcher grocery store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sanford Albert Jacobs Martha Jane Buck ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marty Gosnell/daughter 1260 Magnolia Court Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ROnald S. Wade State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires thet the death certificate be executed ettending physicien end for use as the buriat-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9☐ Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the uncertying cause given in Page 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No page 2 s certificete hes lyocardial 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral is completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certification cause of death (Item 23a) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** EATHRYN JUELLEN BECK 0819 APRIL 2007 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Davs 1 ☐ M 2 🔽 F Hours 76 Director 499-30-9815 Aug 27, 1930 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD Baltimore 1√ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 Murdock Road 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2K Married 1 ☐ Yes 2X No Specify: Specify: white ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) administrative assistant medical traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph Abele Mary Thornton ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 Is
any Injury or other trau Roy W. Joellenbeck/spouse 610 Murdock Road Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🕅 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Stryice Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MĎ 21201 23a. Part1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate druse (Final unknous **Physician** Sev disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2□ No 2☐ ER/Outpatient 3☐ DOA P Yes 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Attending Physician: Hospital or To the Hospital o within 24 hours aft To the Funeral Di completely filled in

should be filed within 72 hours after and Mental Hygiene.

marked other than "natural", or Itel

d 2 should be fil th and Mental H 7 Is marked otl

Baltimore, Maryland 21215-0036

burial-trar ed by the attending physician detached for use as the buria after death.

Director: After this certification in by the funeral director.

Samaretan Horpital, Md 21239

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29a. Certifier

Medical

State

Registrar

29c. License number 0018230

Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KALATHIL SHASH DHARAN

31. Date filed (Month, Day, Year) MAY 03 2007





			1 - For State Registrar	te of Maryland	-	artment of F rtificate of			jiene _{leg. No.} 2 () () ()	1 11271	
	Physici	an	Decedent's Name (First, Middle, Last)	1.				2. Date of Dea Month	th Day Year	3. Time of Death	
	/Media	al	Annelore B 4a. Facility Name (If not institution, give street a	ertha	Jon		r Location of Deat	<u> </u>	26, 2007 4c. County of Dec	6:55 A M	
Å.	Examin	ier	Casey House	na namber)			ville		Montgomery		
Ŀ	Funeral Director		5. Social Security Number 6. Sex 153-16-9048 1□ M 2	7. Age (In yrs. la 84	a <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day May 19,	9. Bi	rthplace (State or Foreign Country) ermany	
	land bw		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits	
	e Mary a-f sh	ector	Maryland Montgomery			Silv	ver Spri	ng		1 □Yes 2X No	
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 21 Bradshaw Ct.	20905	1	10g. Citizen of What C United	country? 1 States				
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funer	1 Never Married 2 Married 1 If Y	s Decedent Ever in U.S ned Forces?]Yes 2\foldsyll No es, Give ar or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:		
Maryland 21215-0036	within 72 ho ene. than "natul he Medica	Completed by	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) Col	leted)	(Give	dent's Usual Occup kind of work done DO NOT use retired Homema	during most of wo	rking	16b. Kind of Business Own Ho	•	
land 2	12 should be filed within ' h and Mental Hygiene. 7 Is marked other than " traumatic event, the Mec	To Be Co	17. Father's Name (First, Middle, Last) Fredrick Sch	anzenbach			18. Mother's Na Bertl		Maiden Surname) Knoerzer		
	1 and 2 shou Health and M tem 27 is mar tem traumat	-	19a. Informant's Name/Relationship (Type. Prin Latrell Jones / Son	nt)	1	ng Address <i>(Street</i> radshaw (r, City or Town, State,	, ,	
Baltimore,	Pages 1 and the part of He ant: If item		20a. Method of Disposition 1 【 Burial 2 □ Cremation 3 □ Remova 4 □ Donation 5 □ Other (Specify)	I from State Pai	ace of Dispo emetery, crer CKLAWN	sition (Name of matery or other place Cemetery	5/1	Date /2007	20c. Location - City o		
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licenses	ANW38	2 R 9	Name and Addre app Fune: 33 Gist A	ss of Facility cal and (Ave., Si	Cremation Lver Spri	Services	20910	
	Physician /Medical		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	that caused the death se on each line. End Stage oue to (or as a consequ	e Alzh			c or respiratory arr	rest,	Approximate Interval Between Onset and Death	
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8760,	ficate be executed physician and is the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Cinter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	ue to (or as a consequ	ence of):						
8	rtificate ng phys as the	Medical	UE FEMALE:								
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	w requires that been signed by should be deta	by	Part II. Other significant conditions contributing	ng to death but not resu	llting in the u	nderlying cause giv	en in Part I.			to the cause of death? Probably 4 XUnknown	
al Records,		Completed		· · · · · · · · · · · · · · · · · · ·				24a. Was a autops perfor 1 Yes		autopsy findings available completion of cause of s	
Vital	Physiclan: The rathis certificate har all director, page	Be	25. Was case referred to medical examiner? 1 ☐ Yes ② YON O	: 1 ∏ Inpatient 2 ∏ E	ED/Outpotion	ıt 3 DOA Oth		ath (Check only or		77	
ō	₹ = <u>₽</u>	n: To	4224		ER/Outpatien 28b. Time of Injury	I 3 DOA	4 🗆 Nursing i	T	ence 6 XJOther (Sp ow injury occurred	ecify) Hospice	
Division	Attenor death ector: by the	Certification:	2 Accident investigation	Place of injury - At hor building, etc. (Specify	me, farm, str	M 1 🗆	Yes 2 □ No	28f. Location (S City or Town	treet and Number or F n, State)	Rural Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Dii completely filled in		29a. Certifier 1 X Certifying Physician:	To the best of my know	wledge, deatl	occurred at the til	me, date and plac	e, and due to the c	cause(s) and manner	as stated.	
	To the Hospita within 24 hours To the Funeral completely filled	Medical		d manner stated.	on and/or in	29c. Licens					
n	7 wit		29b. Signature and title of certifier Lynthia M D	Allean	- An		58032		29d. Date signed (Mor $\operatorname{April} olimits_2$	28, 2007	
	6		30. Name and address of person who complete Cynthia M. Williams,	d cause of death (Item	23a) (Type,	Print)		kville,	MD 20852		
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signat		رير	-				
	negisti	trar MAY 0 3 2007									

DHMH 17 Rev 1/2001

07-03173 Jacqueline Irene Jay Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		For State Certificate of Designator	eath	Reg. I	No.	·
Physician	1	. Decedent's Name (First, Middle,Last)		Date of Death Month Date	ay Year	3. Time of Death 1327 hrs
edical Examine		Jacqueline Irene Jay	O'L Town out position of Dooth	April 25, 200	7 4c. County of Death	1327 1113
A.	4	a. I delity Harrie (if not motionally give street and	City, Town, or Location of Death		Baltimore Cou	nty
Functor	5		f Under 1 Year If Under 24Hrs.	8. Date of Birth(MM/DD/YYYY) 9. Birt	hplace (State or
Funeral Director		218.50.4637 1□M 2XF 52 Yrs.	Months Days Hours Min.	10.26	.1954 Foreig	untry) NY
ay.	_	Usual Residence of Decedent Oa. State 10b. County 10c. City, Town or Location			-	10d. Inside City Limits
Maryland 28a-f show a	5	MD Baltimore Parkvill		Lana	Citizen of What Cour	1 Yes 2 No
he Maryl		1811 Aberdeen Road Apt. A	0f. Zip Code 21234	Tog.	U.S.A.	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	runeral		ecedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black, White
after d	<u>6</u>	or Dates:	es 2 No specify:	work dono	Specify: 6b. Kind of Business/	ndustry
hours natur Exami	99	during most	Usual Occupation (Give kind of v of working life. DO NOT use reti		ob. Killa of Basilless/	ndustry
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215-0036 be filed within 7 mal Hygiene. rked other than rent, the Medics	ᆰ	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
21215-003 ould be filed within I Mental Hygiene. I marked other th ic event, the Medi	8	Kenneth Jay	Kathle		abeth Sp:	
and 2 should lealth and Mer tem 27 is mar traumatic ev	₽┌	Patricia Jay Olson/sister 30275	Holly Lane	Delmar,	MD 2187	5
Baltimore, MD 2 semit. Pages 1 and 2 shou 2 partment of Health and 1 important: If item 27 is 1 njury or other traumatin	1	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Chesapeak	on (Name of cemetery, place)		20c. Location - City or $Beltsvil$	
Baltimore, permit. Pages 1 a Department of the Important: If it injury or other t			ne and Address of Facility Cr			
Bal permi Depar Impo		Y. I The How YMU43 Alto	ernatives 87	17 Greei	n Pastur	eral ballo es Dr. MD
Physician	- 1	23a. Part NEnter the disease, or complications that caused the death. Do not enter the	mode of dying, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
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	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
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18760, rtificate buing physical as the bu		nact 12 months?	I death 3 Ectopic pregr	nancy	23d. Date of delive Month	ry Day Year
Box 687 e death certificate attending ed for use as t	Physician	1 Yes 2 No 9 V Unknown 9 Unknown Other	er (Specify)			
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S, P.C		/		24a. Was a	n 24b. Were a	autopsy findings available
cords, taw require; has been see 2 should b	Completed			autops perform	ned? death?	
Rec The I	힝		26.Place of Death (Chec	1 Yes 2	No 1 🗸	res 2 No
Vital Rec ysician: The l his certificate director, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient	Other		Residence 6 🗸 Oth	er: Scene
Division of Vital Records, tat or Attending Physician: The law requirers after death. "al Director: After this certificate has been sited in by the funeral director, page 2 should be a proper to the page 3 should be a proper to the page 3 should be a proper to the page 3 should be a proper to the page 3 should be a proper to the page 3 should be a proper to the page 3 should be a proper to the page 3 should be a proper to the page 3 should be a proper to the page 3 should be a proper to the page 3 should be a proper to the page 3 should be a proper to the page 3 should be a proper to the page 3 should be a proper to the page 3 should be a proper to the page 3 should be a proper to the page 3 should be a page 3 should	n: To	1 ✓ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Time of Inj	jury 28c. Injury at Work?		ow injury occurred	
tendi Heath.	ațio	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	28f Location (S	treet and Number or F	Rural Route Number, City
Division Hospital or Attent 24 hours after death Funeral Director: tely filled in by the	Certification:	2 Suicide 4 Homicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street	, factory, office building, etc.	or Town, St		
		29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation)	ed at the time, date and place, and on, in my opinion, death occurred	nd due to the cause d at the time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)
To the within To the comple	Medical	29b. Signature and title of certifier /	29c. Licensé number		29d. Date signed (A	
		(and Hallan	O.C.M.E.		April 26, 2007	
		30. Name and address of person who completed cause of death (Item 23a)	treet, Baltimore, MD 212	201		
		Carol Allan, MD Assistant Medical Examiner 111 Penn S 31. Date filed (Month, Day, Year) 32. Segistrar's Signature	ACOU, DARWING OF WID 2 12			
St		MAY 0 3 2007 Bayer &				

permit. Pages 1 and 2 should be filed within 7. Deportment of Health and Mental Hygiene. Important: If item 27 is marked other then "ns any injury or other traumatic event, the Midle 2006. **Physician** /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

rthen "natural", or Iteme 23a or 28a-f ehow the Madical Examinar must be notified at

death v

within 72 hours after

Baltimore, Maryland 21215-0036

Director

δ

Completed

physicien and the burial-transit as the b nding p signed by t Id be detach

this certificate has been siral director, page 2 should After To the Hospital or Attendir within 24 hours after death. To the Funarel Director: At completely filled in by the fu death.

Division of Vital Records, P.O. Box 68760,

	21, Signature of Funeral Service Lio hs	θ		2. Name and Address of Fability Chatman-Harris Fi 5240 Reisterstown Rd Baltimore						
4	23a. Part1. Ever the disease, or complic shock, or heart allure. List only on	eations that caused the death. Do not e cause on each line.			Approximate Interval Between					
	Immediate Cause (Final disease or condition resulting in death)	Sepsis					Onset and Death			
	Sequentially list conditions b.	Due to (of as a consequence of) Pur for catecl Due to (or as a consequence of)	duod	enal u	ler		2 months			
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ונפו	d	AND DESCRIPTION	mallit	us			10 years			
ysiciaining	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23b. Was decedent pregnant in the past 12 months? 1								
- A D -	Part II. Other significant conditions con	-	he underlying cau	se given in Part I.		1/	te to the cause of death? Probably 4 Unknown			
) Indian	Menustis C				24a. Was an autopsy performs	prior	e autopsy findings available to comptetion of cause of h? Yes 2 No			
ט	25. Was ca referred to medical			26. Place of Dea	ath (Check only one)					
2	examiner?	ospital: 1 XInpatient 2 ☐ ER/Outpa	atient 3 DOA	Other: 4 Nursing H	lome 5 ☐ Residen	ce 6 ∏Other (Specify)			
allon.	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tim Inju	ne of 28d	. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how					
	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, o	office	28f. Location (Stre City or Town,	et and Number o State)	r Rural Route Number,			
alical		ician: To the best of my knowledge of ler: On the basis of examination and/of and manner stated.								
3	29b. Signature and title of certifier		29c. l	icense number	290	I. Date signed (N	fonth, Day, Year)			

State Registrar

person who completed cause of death (Item 23a) (Type, Print)

MD RES-000 April 29, 2007

death (Item 23a) (Type, Print)

blo North Wolfe Street Baltmore Margiand 2,287

- 600 North Wolfe Street Baltmore Margiand 2,9106 31. Date filed Month, Day, Year) Kadhleen Rhodes 32. Registrar's Signature

MAY 0 3

DHMH 17 Rev 1/2001

Jamal Knox UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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200	1		1 4	Î	

		1- For State Certificate of Registrar	Death	Re	g. No.				
Physicia Medical Examin	n/	Decedent's Name (First, Middle, Last)		2. Date of Death Month April 30, 20	n Dav Year	3. Time of Death 1915 hrs			
		4a. Facility Name (if not institution, give street and number) 500 Half Mile Court	b. City, Town, or Location of D Baltimore		4c. County of Death				
Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	If Under 1 Year If Under 2 Months Days Hours	4Hrs. 8. Date of Birth Min. 01/04/1	h(MM/DD/YYYY) 9. Birth Foreign Cou				
daryland 28a-f show any 1 at once.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. City Town or Location	Baltimore	e		10d. Inside City Limits 1 X Yes 2 No			
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	Öİ	0350 RIVELVIEW RIVERIGE	10f. Zip Code 21222		g. Citizen of What Coun USA	try?			
면 5 티	by Funeral	1 X Never Married 2 Married Armed Forces? If Yes 2 X No 1 Service Armed Forces? If Yes 2 X No 1 Pates:	Decedent of Hispanic Origin? s, specify Cuban, Mexican, Pt Yes 2 X No specify:	uerto Rican, etc.)	White, etc. African A Specify:	merican			
5-0036 led within 72 hours after Hygiens "natural", other than "natural", the Medical Examiner	Completed	45 Decoderate Education (Chaption and highest grade completed) 160 Decoderate	s Usual Occupation (Give kind st of working life, DO NOT use		16b. Kind of Business/Ir				
Jre, MD 21215-0036 ss I and 2 should be filed within 7 of Health and Mental Hygiene. If item 27 is marked other than ther traumatic event, the Medica	Be Com		student 18.Mother's N	Name (First, Middle, M	taiden Surname)	ty Public Sch.			
MD 21 rd 2 should that and Mer m 27 is mar aumatic eve		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Numbe 30 Riverview Aver		ore, Maryland	21222			
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ex-		1 X Burial 2 Cremation 3 Removal from State crematory or oth King Memori	al Park (Date 05/07/2007	20c. Location - City or Randallstown,				
		Aumeria Jano	ame and Address of Facility 88 North Gilmor St	treet; Baltin	ral Home, P.A. more, Maryland				
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	e mode of dying, such as card	liac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death			
	<u>.</u>	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
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Box 68760, e death certificate by the attending physic ed for use as the bur	Physician/Me								
ords, P.O. Be wequires that the de is been signed by the should be detached from			nderlying cause given in Part I		bacco use contribute to to 2 No 3 Prob				
tal Records, P.O. Box 68: inn: The law requires that the death certifi- certificate has been signed by the attending ector, page 2 should be detached for use as I	Completed by			24a. Was a autops perfor	sy prior to c med? death?	opsy findings available ompletion of cause of Source No.			
ital Rician:	8	25. Was case referred to medical examiner?	26.Place of Death (Ch		Residence 6 ✔ Other	Scana			
ion or tending leath. for: Afte	ation: To	27 Manner of Death 28a Date of Journ 28b Time of In		28d. Describe h	now injury occurred				
Division To the Hospital or Attentwith 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Parking Lot 28f. Location (Street and Number or Rural Route Number or Town, State) 500 Half Mile Court, Baltimore, MD							
8 5	edical	29a Certifier	on, în my opinion, death occur	e, and due to the cause rred at the time, date a	e(s) and manner as state and place, and due to the	ed. e cause(s)			
	•	Silar 19	29c. License number O.C.M.E.		29d. Date signed <i>(Mor</i> May 1, 2007	ith, Day, Year)			
り			n Street, Baltimore, ME	21201					
Sta Registi		野水V 9 2007 M	uli)						
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		1 - State Amend #20b, perFI Registrar	H, g867, 5/3/0	7 TT Ce	rtificate c	f Health and Months		g. No.	3. Time of Death
hysicia		Decedent's Name (First, Middle, Last) COL OMON		νnı	KOTOV		Month MAY	Day Ye	ar 3
/Medic	al -	SOLOMON 4a. Fecility Name (If not institution, give s	street and number)	KUI		n, or Location of Death	1 1	4c. County of D	Deeth
Examin	er	SWAI HOSPITAL OF		πĒ	BALTI			N/A	
uneral rector			7. Age (In	yrs. last birthday 88 Yrs.	Months Da	vs Hours Min.	8. Date of Birth (Month, Day, 05/03/19	Year)	Birthplace (State or Foreign Country) RUSSIA
death with the Maryland ms 23a or 28a-f ahow rmat be rediffed at		Usuel Residence of Decedent 10a. State MD BALTIMO		c. City, Town or L	ocation INGS MIL	.LS			10d. Inside City Limits 1 ☐ Yes 2 No
or 28a	Director	10e. Street and Number	011405		10f. Zip Coo		10	og. Citizen of Wha	
s 23a	eral	46 PICKERSGILL S	QUARE 12, Was Decedent Ever	in U.S. 13	Was Decedent	21117 of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - /	S.A. American Indian,
id other than "natural", or items 23a or 28a-f show event, the Medical Exercitive must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	110.0.	Il Yes, specify (1 ☐ Yes 2 💢	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	Rican, etc.)	Black, V	WHITE
no "natura Medical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Giv	edent's Usual Oc re kind of work do DO NOT use re	one during most of work stired)		16b. Kind of Busin	
other th		(Fig. 1) (Fig. 1)	5+	MECH	ANICAL_	ENGINEER 18 Mother's Nam	ne (First, Middle, N	ENGINEE	RING
marked oth	To Be	17. Father's Name (First, Middle, Last) JOSEPH	95-4	KOKOT		SARA		AG	RANOVICH
7 is m traum		19a. Informant's Name/Relationship (Ty							
t: If item 27 is marke y or other traumatic		SAMA LEBEDEV / D 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State (Ob. Place of Disp CHEVRA	HAVS or other	SED 05/02		S MILLS 20c. Location - Cit ANDALLST	MD 21117 y or Town, State OWN, MD
Important: If it any injury or o once.		21. Signature of Funeral Service Licens			havas 22. Name and Ad	ddress of Facility S ISTERSTOWN			OS., INC. LE. MD 21208
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of	lications that caused the	death. Do not e	nter the mode of	dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
sician		Immediate Cause (Final disease or condition	SYSTEMIC						
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ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2007 Month **Physician** 2, Lascola Rhoda Ι. 5:25 AM May /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie Anne Arundel Mariner Health of Glen Burnie If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🕱 F JUN 1 1920 220-16-1980 86 WV Director Usuel Residence of Decedent 10d. Ioside City Limits the Maryland 10c. City, Town or Location 10a State 10b. Count permit. Fages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinator must be notified at 1 Yes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21230 1711 Harman Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: δ White 3 ¥Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Franklin Ida Virginia Ashby Benjamin Everts 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Perkins - friend 1507 Parksley Avenue, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5/3/2007 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 21. Signature of Funeral Service Lice ²², Name and Address of Facility Cremation Society of Maryland, 299 Frederick Road, Baltimore, Todd Dring 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Set only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last main for as Examiner use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician 90 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month signed by the atter in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 2 No 26. Place of Death (Check only one) the funeral director, 25. Was case referred to medical examiner? Be Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death ne Hospital or Attending Pont No. 24 hours after death. Certification: Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 / Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier

State Registrar

Registrar MAY 0 3 2007

SHOK

31. Date filed (Month, Day, Year)

TENJEE

32. Registrar's Signature

30. Name and address of person who completed ouse of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygierië

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	l⇔ For State Registrar	State of Ma	aryland			nt of H te of L			Ra	g. No.	07	4.278		
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	, K.	,	L	inds	ny		M	ate of Death Ionth	Day	Year	3. Time of Death		
	Examin		4a. Facility Name (If not institution, give s Long View Nursi					r, Town, or iches	Location of the	Death		4c. Col Cari	inty of Death			
	uneral irector		5. Social Security Number 6. Sex 577-24-5925	м 2 X F 87	e (In yrs. la	nst birthday) Yrs.	If Und Months	Days	If Under 24 Hours	Min. Jai	ate of Birth Month, Day, 1 27	Year) 1920	9. Births MD	place (State or Foreign ntry)		
Maryland	fed at	tor	Usual Residence of Decedent 10a. State 10b. County MD Carrol1			Town or Lo							1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
with the	3a or 28e at be notil	Funeral Director	10e. Street and Number 6402 Oakland Mill	Road		,	10f. Z	ip Code 2178	4		10	g. Citizen USA	of What Cou	ntry?		
5-0036 72 hours after death with the Maryland	riber. riber "naturel", or liems 23s or 28s-1 show the Madical Examinar must be notified at	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:		1	f Yes, sp	edent of Hi ecify Cuba 2 No	spanic Origin n, Mexican, I Specify:	n? (Specify) Puerto Rican	(es or No-		Race - Americ Black, White, ecity: Wh:	etc.		
within	then "nature the Medical E	Completed	15. Decedent's Edu (Specify only highest grade		+)	16a. Deced (Give life. L	kind of w		urina most o	of working			of Business/in z Clotl	dustry		
Viand 2	d othe	To Be Co	17. Father's Name (First, Middle, Last) Samuel A. King						18. Mother's Rosie	s Name (Firs Se1by	it, Middle, M	faiden Sun	name)			
	27 to m		19a. Informant's Name/Relationship (Ty, Joy Graham (daught)		or)								wn, State, Zip MD 2178			
Baltimore, permit. Pages 1 ar	nt: if item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Ce	ace of Dispo metery, cren Count	natory or	other place		Date -3-07			on - City or To ${ m ville}$,			
Balti Permit.	Important: if ite		21. Signature of Funeral Service License Page Aaight	"medreyo"	*					Haight esville				Chape1		
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J 5	been signed by should be detac	۵	Part II. Other significant conditions cor	ntributing to death b	ut not resu	lting in the ur	nderlying	cause give	n in Part I.			accouse o		he cause of death?		
	ate has	Completed								_	24a. Was an autopsy perform	/	4b. Were auto prior to co death? 1 \(\sum \text{Yes} \)	opsy findings available impletion of cause of		
n Of	After this certific funeral director,	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1 Inpatie 28a. Date of Inju (Month, Da	ry	FVOutpatien 28b. Time of Injury		28c. Injury Work	4 Nurs	28d. (nce 6 🗆	Other (Special	(y)		
DIVISION et or Attending		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.			eet, facto			28f. L	ocation (Str City or Town		umber or Rura	al Route Number,		
Hospit 4 bour	Funer ely fill	Medical (29a. Certifier 1 Cartifying Physical Control (Check only one) 2 Medical Exami	sician: To the best nar: On the basis of and manner sta	examinati	vledge, death ion and/or in	occurre vestigation	d at the tim on, in my op	e, date and inion, death	place, and d occurred at	ue to the ca the time, da	use(s) and ite and pla	d manner as s ce, and due t	stated. o the cause(s)		
To the	To the	Me	29b. Signature and title of certifier	<u>`</u>	_		> 2	9c. License	number 7375	73	29	Met	gned (Month,	Day, Year)		
	}		30. Name and address of person who co	mplened cause of d		23a) (Type, √0, √	Print)	Re	eteste	0~~	MD	71	136			
	Sta Registr		31. Date filed (Month, Day, Year)	32-Registra			NE S				<u>.</u>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician Lester Frank Lohse /Medical 4c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Agnes attimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, You Sept 28, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Social Security Number Year) 1921 Illinois **Funeral** Months Days 1 M 2 □ F 346-14-0289 85 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 No MD Baltimore Director Lansdowne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 320 1/2 Third Avenue 21227 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify. Baltimore, Maryland 21215-0036 Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Electrician Electricial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ Violet Goup Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Lohse/Wife 320 1/2 Third Avenue Baltimore Md 21227 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakeview Memorial 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 □Removal from State 05-03-2007 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify)

21. Signatur 1 neral Service Licen Park
22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD 21227 bee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on any like. Approximate Interval Between Onset and Death Immediate Cause (Final neumoma aus **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner bois Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a o nsequence of): Examiner The law requires that the death certificate be executed burial-tran the attending physician and Due to (or as a consequence of): Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 2 No 3 ☐ Probably 4 Unknown 1 Tyes the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No performed 2 No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**V**No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To ō 27. Mann of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl e Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical completely within 24 29c. License number 29d. Date signed (Month, Day, Year) P20556 Caton Ave Baltimore MD 21229

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 20, 2007 Month Physician 10:55 PM April Thomas Lynch /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner Baltimore Gilchrist Hospice Towson If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months 1 ☑ M 2 ☐ F 82 Jan 6, 1925 219-12-9742 Maryland Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Baltimore Timonium Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1508 Norman Avenue 21093 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 11 Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: white 43-45 Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation unk 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) civil engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill thent of Health and Mental Heant: If item 27 is marked oth jury or other traumatic event Be Joshua Howard Lynch Edna Olivia Nagle ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeannette Lynch/spouse 1508 Norman Avenue Timonium, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street re of Euneval Service Licensee Remaid S. Wade Baltimore, MD 21201 23a. Part1\ Enter the disease, or/complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) month Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-tra Due to (or as a consequence of): physician Physician/Medical the IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy atter for u in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has I autopsy perform certificate 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this P 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

P.O. Box 68760. Division or Vital Records,

To the Function after death.

To the Funeral Director: After the function of t Fo the Hospital

29a. Certifier (Check only 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Medical

State Registra

		1 - State Registrar Ce	artment of Health and Mental Hyg rtificate of Death	iene200/1281
Physici /Medi		Decedent's Name (First, Middle, Last) LEONARD	LEVITAS 2. Date of Death Month Afficial	Day Year 3. Time of Death 1913 M
Examir		4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL OF BALTIMORE	4b. City, Townsor Location of Death 844TIMORE	4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 10/09/11)	
Maryland f show ied at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L. MD N/A BALTIMO		10d. Inside City Limits 1
er death with the Marylar Items 23a or 28a-f show ner must be notified at	Director	10e. Street and Number 3031 FALLSTAFF ROAD APT. 305	10f. Zip Code	Og. Citizen of What Country?
1215-0036 within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral	· · · · · · · · · · · · · · · · · · ·	21209 Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ♥ No Specify:	U.S.A. 14. Race - American Indian, Black, White, etc. Specify: WHITE
and 21215-0 be filed within 72 hc tal Hygiene. d other than "natur event, the Medical	Completed	(Specify only highest grade completed) I (Give	e kind of work done during most of working DO NOT use retired)	6b. Kind of Business/Industry
and 2 be filed ntal Hygi ed other event, t	8	17. Father's Name (First, Middle, Last) SOLOMON LEVITA	SALES 18. Mother's Name (First, Middle, N ROSE	AUTO faiden Surname) OCHS
Marylanc and 2 should be feath and Mental B	ပ္	19a. Informant's Name/Relationship (Type. Print) 19b. Maili	ng Address (Street and Number or Rural Route Number,	City or Town, State, Zip Code)
of Heg		20a, Method of Disposition 20b. Place of Disposition	osition (Name of Date 2 matory or other place)	BALTIMORE, MD 21209 20c. Location - City or Town, State DWINGS MILLS, MD
Baltime permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee 2	1-1/1-//	SON & BROS., INC.
by Sicial Description of the Principle o	edical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Interval Between Onset and Death
I Records, P.O. Box 687 The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Physician/Medi		□Ectopic pregnancy □ Other (<i>specify</i>)	23d. Date of delivery Month Day Year
cords, P.O. wrequires that the debeen signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the CORONARY HRTHRY) ISWASK, WITTRAL VAL	underlying cause given in Part I. 23e. Did tob VAL (LACACHMACH)T 1 ☐ Ye	acco use contribute to the cause of death? s 2XNo 3☐ Probably 4☐Unknown
Division or Vital Records, or Attending Physician: The law requires ta after death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Be Completed by	ATRIAL FIBRILLATION CONGRISTIVE HEARE COLONARY HETHER BYMSS GRAFT, TOLCO 25. Was case referred to medical	24a. Was are autops; perform 1 Yes 2 26. Place of Death (Check only one	prior to completion of cause of death? No 1 □ Yes 2 No
vision or Vital Attending Physician: r death. ector: After this certification the funeral director, I	2	examiner? 1 Yes 2 No Hospital: inpatient 2 ER/Outpatie 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	nt 3 DOA Other: 4 Nursing Home 5 Reside of 28c. Injury at Work?	nce 6 □Other (Specify)
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ti	Certification:	□ Accident investigation 3 □ Suicide 6 □ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No reet, factory, office 28f. Location (Str City or Town	eet and Number or Rural Route Number, State)
ne Hospital n 24 hours ne Funeral	Medical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and due to the can nvestigation, in my opinion, death occurred at the time, da	use(s) and manner as stated. ate and place, and due to the cause(s)
To the within To the Comp	Me	29b. Signature and time of certifier ML	29c. License number 29	d. Date signed (Month, Day, Year)
10		30. Name and address of person who completed cause of death (Item 23a) (Type, When Aville Brown MD 2401		& Britimore MA
Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	partie	/

DHMH 17 Rev 1/2001

MAY 0 3 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Patricia Mindte 5:30 4. May 2607 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Falling Wroter Circle #102 Germantown Montgomery If Under 1 Year | if Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🚉 🕇 Days Hours Min. 29 044-56-1738 August Director Connecticut Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~- " any hijury or other traumatic even." 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1. Yes 2 □ No Directo Montgomery Germantown Marylond 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20874 12902 Fallina Water Circle # 102 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuai Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Accountant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernest Kenneth Godfrey, Ir Patricia Ann Szulczwski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) Husbarol 12902 Falling Water Circle # 102 Germantown, Thomas Mindte 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Androny Gifts Registry May 2, 2007 Hanover, M 22. Name and Address of Facility Anatomy Gifts Registry Hanover, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 7522 Connelley Prive suitef. Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** lultiste Scheros16 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) I ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, after death.

> State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

9815 Main St. Domascus MD Senjamin + Papoi D.O. 31. Date filed (Month, Day, Year) MAY 0 3 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** Sonva Mason APRIL 21 2007 /Medical 9:59 Α 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER LAPLATA

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. CHARLES Social Security Number . Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1 □ M 2 🗓 F 192-42-3661 54 Director May 5, 1952 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Charles White Plains 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3935 Hedgemeade Court 20695 Funeral U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married MASON, SONYA Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude Smith Nelwyn Tyiska 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jaleela Prioleu(Daughter) 3935 Hedgemeade Ct., White Plains, MD 20695 20b. Place of Disposition (Name of cemetery, cramatory or other place)
Restland Mem. Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dong# 5 ☐ Other (Specify) 4/30/07 Monroeville, PA neral Service Licens 21. Signature of 22. Name and Address of Facility
Watts Memorial Chapel 808 Talbot Ave., Braddock, PA 15104 ennie Mmen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a cons Box 68760, physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9□Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Yes 2 No 3 Probably 4 Unknown Completed page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 2 No Physiclan: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) aminer' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 2 KER/Outpatient 3 □ DOA 2 1 Inpatient After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural М 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: completely filled in by the f 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D-0057999 Terrace Dr. 11637 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Svite 103 Waldorf, MD20602 sha. a TIWala Smeria.

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 30, Day 2007 **Physician** 7:16 A M Dolores M. McShane /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air 8. Date of Birth (Month, Day, Year) March 9, 1929 9. Birthplace (State or Foreign Country) New Jersey If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🛣 F 78 Director 156-20-0132 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 'natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2X No Directo Harford Forest Hill Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21050 103 C Sunshine Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Specify White 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Gerning George Smith 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 103 C. Sunshine Ct. Forest Hill, MD 21050 George V. McShane (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Bayview Crematory 4 □ Donation 5 □ Other (Specify) 5-3-2007 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee 610 W. MacPhail Rd. Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner bacco Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last s a consequence of): Examiner Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months 1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 10 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Hospital or Attending Pl 24 hours after death. Funeral Director; After the 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cortifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Day, Year) 32 Registrar's Signature State Registrar

Récords,

Division or Vital

			For State Registrar	State of Mai	ryland /	-	artment of H			giene 0 0	7 14285
			1. Decedent's Name (First, Middle,						2. Date of Dea	ath	3. Time of Death
	Physicia		CHARL	ES ME	OST	5	R.		APRIC	2ggn	Year 7-30P M
	/Medic Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, or	Location of Dea	th	4c. County of	f Death
	LXamiii		Genesis Multi M	fedical Cente	er		Tow	son		Balt:	imore
	Funeral			6. Sex 7. Age	(In yrs. last b	irthday)	If Under 1 Year	If Under 24 Hr.		h (Year)	Birthplace (State or Foreign Country)
	Director		216-28-9998	1⊠M 2□F 7.	5	Yrs.	Months Days	Hours Mil	Oct. 29		Maryland
	g		Usual Residence of Decedent								404 tanida Oirettinia
	nylar	_	10a. State 10b. County		10c. City, To	wn or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	e Ma Sa-f s	cto	Maryland Ba	altimore			Notti	ngham			
	ith th	Director	10e. Street and Number				10f, Zip Code			10g. Citizen of Wh	nat Country?
	23a	rai	18 Gunhurst Gart				2123			U.S.	
	r de	Funeral	11. Marital Status	12. Was Decedent Every Armed Forces?		13.	Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (n, Mexican, Pue	Specify Yes <i>o</i> r No- rto Rican, etc.)		- American Indian, , White, etc.
36	72 hours after death with the Maryland natural', or Items 23e or 28e-f show disat Examilier: Ast be inclified at	by Fu	1 Never Married 2 Marrie	IT YES, GIVE)		1 ☐ Yes 2X No	Specify:		Specify:	White
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7	"nat	lete	15. Decedent's (Specify only highest	grade completed)	16	(Give	kind of work done a DO NOT use retired	luring most of w	orking		tional Assn.
12	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)		Educator				Workers
2	be filed within 72 hours after death with the Marylan tal Hygiene. Id other than "natural", or liems 23a or 28a-f show seent, in a Maclical Examination and by inclined at		17. Father's Name (First, Middle, L				Ludcacol		ame (First, Middle,		
an		o Be	Conrad Most	,			İ	А	gnes Deml	neck	
2	2 should be and Mental is marked raumatic sv	은	19a. Informant's Name/Relationshi	ip (Type, Print)	19	b. Maili	ng Address (Street a				State, Zip Code)
Maryland 21215-0036	교문문교		Patty Sue Most			18 0	unhurst G	arth N	ottinghar	m Marula	and 21236
	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition	(wile)	20b. Place	of Dispo	sition (Name of		Date		City or Town, State
Baltimore,	nt of nt of t: If it		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.	3 Removal from State		-	matory or other place		07.70007	D-144	W11
量	ntani njury		21. Signature of Pursual Service L	**	Garde	ens 2	of Faith 2. Name and Addres	is of Facility C	04/200/	Baltimor	re, Maryland
Ba	Depa Impo any ir		11116								land 21236
			23a. Part1. Enter the disease, or o	complications that caused t	he death. Do						Approximate
			shock, or heart failure. List of Immediate Cause (Final	only one cause on each line	9.						Interval Between Onset and Death
	Fnysician /Medical		disease or condition resulting in death)	a. END	2-	1 A	GF D	EMES	NTIA		Montes
	Examiner			Due to (or as a	O) P	e oī): ⊿~✓	10~	PNF	TINO	21,24	10.0
6		5	Sequentially list conditions,	b. Due to (or as a			,			0171	- Land
J	ted nsit	i i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	FAN	NRE		TO T	HRIV	IE		monto
	death certificate be executed e attending physician and of for use as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a							
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687	ficate t physics the t	edica		0.							
Вох	leath certifica attending ph	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			7			23d. Date	of delivery
m	death a atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at t			□Ectopic pregnancy □ Other (specify)			Mont	th Day Year
0	that the de ted by the a detached	hys	9 □ Unknown	9□ Unknown							-
0	that hed b	by PI	Part II. Other significant condition	ns contributing to death but	t not resulting	j in the t	inderlying cause give	en in Part I.	23e. Did to	obacco use contrib	bute to the cause of death?
rds	quires n sign								10	Yes 2□No 3	3 Probably 4 Donknown
Vital Records,	law requires that the as been signed by th 2 should be detache	Completed							24a. Was	an 24b. W	ere autopsy findings available
Re	a = 0	mc								rmed? de	rior to completion of cause of eath? □ Yes 2□ No
tal	lan: The rtificate stor, pag	O	25. Was case referred to medical					26. Place of D	1 ☐ Yes eath (Check only o		2100 22100
	Physiclan: this certific ral director,	0 8	examiner? 1 ☐ Yes 2 ☐ Mo	Hospital: 1 Inpatien	t 2 ER/C	Outpatie	nt 3 DOA Othe		Home 5 ☐ Resid		r (Specify)
of		T:u	27. Manner of Death	28a. Date of Injury	/ 28b	. Time o				now injury occurre	
on	th. : After	atio	Natural 5 Pending 2 Accident investig		(ear)	Infury		Yes 2 □ No			
Division	Attending er death. rector: After by the fune	ifica	3 Suicide 6 Could n		ry · At home,	farm, st	reet, factory, office		28f. Location (Street and Number	er or Rural Route Number,
Ö	al or Att	Certification;	4 - Homeide	Building, Blo.	(Specify)						
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in D			g Physician: To the best of Examiner: On the basis of							
	in 24 he Fi pletel	edical	one)	and manner stat							
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	5		30. Name and address of person v	who completed cause of de	0 1		Print)		2000	suite	2045
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	Regist	rar	MAY 0 3	2007 10000	15	1	refer !				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 4:45 PM April 20, 2007 Marjorie Mlinarchik /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🖫 F Feb 10, 84 South Carolina 1923 Director 248-24-2323 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anneas. 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County 1√ Yes 2 No MD Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21214 USA 6418 Birchwood Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: white þ 3 ∑Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Lafayette Miller Bertie Barr ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Cathy Mlinarchik/daughter 6418 Birchwood Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 □ Qther (Specify) 21. Signature of Euneral Pervice Licensee Rouald S. Wang 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 2120123a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) month STA Physician /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed' 1∐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Horp (% Hospital: 1 ☐ Yes 2 ☐ No Medical Certification: To 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 BMC

6701

32 Registrar's Signature

29c. License number

N. Chriles St

29d. Date signed (Month, Day, Year)

07-02850 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Brian Marshall State of Maryland / Department of Health and Mental Hygiene 2007 1- For State Certificate of Death Registrar Reg. No. Physician/ Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Day April 14, 2007 **Medical Examiner** 0850 hrs Brian N. Marshall 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 956 North Hill Road Baltimore 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or **Funeral** Foreign Months Days Hours Min Director Country) MD 216-38-3852 1X M 2 F 6.5 6-3-1941 Vrs Usual Residence of Decedent Inv 10a State 10b County 10c. City, Town or Location 10d Inside City Limits 23a or 28a-f show notified at once. Yes 2 No MD Baltimore City permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28af sho injury or other raumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 956 North Hill Road 21218 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 1 X Yes Divorced If Yes, Give Year White Yes 2 No specify. 3 Widowed 4 Specify: ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 12 Metalurgist Metal Mfg. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Norris Marshall Rosel<u>yn Gould</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Tracey Stevens - Niece Trail, Severna Park. MD20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Bayview Crematory 4-28-07 Donation 5 Other Specify Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Service/Licensee Bradley-Ashton Funeral 2134 Will Spring Road OW Approximate Interval **Physician** 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and failure. List only one cause on each line /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED burial Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy phy the t 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o δ Δ. 1 Yes 2 V No 3 Probably 4 Unknown Cirrhosis of liver Completed Records, hould 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has performed? death? page ✓ Yes 2 1 🗸 Yes No 2 No To the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner? Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene Inpatient 2 2 1 Yes No After tl funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Division Pending Yes 2 No Funeral Director: stely filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after 3 Could not be Suicide or Town, State) determined (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 15, 2007 When 5 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State BAR. 2007 03 Registrar

07-03289

litton Granville		ris State of Maryland / Department of Hearth of State of Maryland / Department of Hearth of Dearth	Reg	No. 2007	14280	
Physicia I Exami	an/	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month April 30, 20		3. Time of Death 0640 hrs
n 1 Exami		Clifton Granville Norri 4a. Facility Name (If not institution, give street and number) 4b. City	, Town, or Location of De		4c. County of Death	
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Funeral Director		227 06 0949	nder 1 Year If Under 24 oths Days Hours	Min. Jan. 23	(MM/DD/YYYY) 9. Birl	
	Į	Usual Residence of Decedent		Puntes	71300 60	
ow any		10a. State 10b. County 10c. City, Town or Location $Raleigh$				10d. Inside City Limits 1 X Yes 2 No
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hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once.	Dire	5055 Neuse Commons Lane 2	7616		USA	
ath with	Funeral	1 XNever Married 2 Married Armed Forces? If Yes, spe	dent of Hispanic Origin? cify Cuban, Mexican, Pu		14. Race - Ameri White, etc.	can Indian, Black,
after de	by Fu	1 Yes 2 X No 3 Widowed 4 Divorced If Yes (ive Year or Dates: 1 Yes	2 X No specify:		Specify: B1	ack
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Injury or other traumatic event, the Medical.		17. Father's Name (First, Middle, Last) Clifton Denny	18.Mother's N Peggy	ame (First, Middle, Ma Payne	alden Sumame)	
212 ould be J Menta s marke	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addre	ess (Street and Number	or Rural Route Numb		
MD and 2 sho alth and 2 sho sm 27 is		Lisa Norris-Wife 5055 Ne	use Commo		Raleigh, I	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 XBurial 2 Cremation 3 Removal from State Pleasant V	ce)		Annanda 1	
altin mit. Pa partmes portan ury or		4 Donation 5 Other Specify:	- 1 4 1 1 6 15 10 14		neral Se	
		Robert B Salur F 2605 23a. Part I. Enter the disease, or complications that cause the death. Do not enter the modern that the control of the	S.Shirli	ngton Rd	.Arl.Va.	22206 Approximate Interval
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Examiner		or condition resulting in death) Due to (or as a consequence of):	di diocasc			
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Box 687 death certifice the attending p	ıysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of 5 Other (S	pecify)			
b.O. that the red by t		Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ds, F equires een sign	Completed by	Chronic alcoholism		24a. Was ar		topsy findings available
Division of Vital Records, tal or attending Physician: The law requirns after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	mple			autopsy perform	ned? death?	completion of cause of
al Re ian: Th ertifica ctor, pa	Be Co	25. Was case referred to medical	26.Place of Death (Ch			2 10
f Vit Physici er this c		examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 27. Manner of Death 28a. Date of Injury 28b. Time of Injury	DOA Other No.	<u> </u>	tesidence 6 Other	r: Scene
on of ' ending Ph ath. rr: After t	Certification:	1 X Natural 5 Pending (Month, Day,Year)	1 Yes 2 No		w injury occurred	
Divisior pital or Attencours after death teral Director: filled in by the	tifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fact	ory, office building, etc.	28f. Location (Str or Town, Sta		ıral Route Number, City
Hospital 24 hours Funeral		4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at	the time, date and place			ed.
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	Check only 2 Medical Examiner: On the best of my knowledge, death occurred at one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.				
	Me		29c. License number		29d. Date signed (Mo	nth, Day, Year)
of d		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		April 30, 2007	
3 8			et, Baltimore, MD 2	21201		
S	tate	31. Date filed (Month) (Day, Year) 2007 32. Figistrar's Signature	7.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nelson Year Month **Physician** 7:23 PM haun April 26 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Battimore Hospital Cuty Johns Hop kins If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year Days 215-94-955 1**⊠** M 2□ F Yrs. Director WASH Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10b. County Examiner must be notified at 1 ☐ Yes ≥ No Director MARVLAND BALTIMORE 28a-f NOT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 23a Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 'natural", or items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4or 5+) 15 ABLED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARK 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RLEEN RICHARDSON NOTTINGHAM, MO 212. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 □Removal from State NCOLN MEM CEME:05-05-07 4 Donation 5 ☐ Other (Specify) SUITLAND MD 21. Signa ure of Foreral Assice Licensee 22. Name and Address of Facility BROWN JR. FUNERAL HOME 23a. Part1 Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BALTO, HD. 212 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to [or at a consequence of f): facture days **Physician** /Medical Examiner udomano. S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ystic be executed bunial-transit Fibrosis VZOYS and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No cate has been signed by the page 2 should be detached Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 21 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 patient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tiffe MD RES-000 2007 31. Date filed (Month, Day, Year) 30. Name and address rson who completed cause of death (Item 23a) (Type, Print) Baltmore 600 St. Wolfe 32. Registrar's Signatur State Registrar

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07-	0300)3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Francis Joseph C		er, Jr. 1- For State	State	of Maryla		partment <i>ertificate</i>			nd Me	ental H	, 0	9.~.			7	29
Physicia		Registrar 1. Decedent's Name (Firs	t, Middle,La	ast)		Crimodic	01 2	- Catif			2. Date of Dea	eg. No ith		- 1;	3. Time of Dea	ith
Medical Examir	ner	Franc	is	Joseph	Orne	r, Jr.					Month April 19, 2	Day 2007	Year		0830 hrs	
1		4a. Facility Name (if not in Railroad Tracks			,		-	City, Town, o		on of Death	1	4	c. County of	Death		
Funeral		5. Social Security Number				s. last birthday		If Under 1 Ye		nder 24Hrs	2 Data of Bi		Carroll	O Divib	place (State or	
Director	1				- , ,	-	` -	Months Da	_	urs Min		•	1	Foreign Cour		
		231-15-8960 Usual Residence of Dece		<u>X</u> M 2 F	42	۷	Yrs.				Feb.	2/,	1965	Cour	ntry) CA	
any	Ì		County		10c. C	ity, Town or Lo	ocation							1	10d. Inside City	y Limits
and show	5	MD C	arrol:	1	Ne	ew Wind	lsor								1 Yes 2	X No
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urs afi tural'	a p	15. Decedent's Education		or Dates:			_	Usual Occup		•	work done	16b.	Kind of Bus			
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15-C filled v I Hygi od oth	ပ	17. Father's Name (First,	Middle, Las	t)					i -		e (First, Middle,		,			
2121 uld be fi Mental I marked	o Be	Francis Jo 19a. Informant's Name/Re	oseph	Orner,	Sr.	19b Ma	ailina A	ddress (Stre	Ma net and N	ry Do	orothy Rural Route Nu	Rhoa	ads	State	Zin Codo)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	٦	Mary Orner		ther							olk, VA		3502	, Glate, i	-ip Code)	
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Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral S			100	2	22. Nam	ne and Addres	ss of Fac	ility W	godlawn	Fu	neral	Hom	e and	
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Physician /Medical		Part I. Enter the dise failure. List only one	ase, or com cause on e	each line.						s cardiac o	or respiratory an	rest, sh	ock, or hear	rt	Approximate Between Ons	
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	je l	Sequentially list condition if any, leading to immedia cause. Enter Underlying	te	Due to (or as a	consequence	e of):										
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0, e be executed ysician and burial - transit	dical	X UNPENDED		AMENDED-	nerME.	g867 , 5/4	↓/07	TT								
68760 certificate b nding physise as the bu	šί	IF FEMALE: 23b. Was decedent pregna	ant in the	23c. If yes, o	outcome of pr							23	3d. Date of d	lelivery		
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	siciar	past 12 months?		1 Live bi	inth ant at time of	death 5	Fetal	death 3 (Specify)	Ecto	pic pregna	ancy	4	Month	Da	y Ye	ear
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.O. hat the ed by letache	D P	Part II. Other significant	conditions	contributing to	death but no	ot resulting in t	he und	erlying cause	given in	Part I.				_	e cause of dea	
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of Vital Records, ng Physician: The law requir Nher this certificate has been si neral director, page 2 should be	Completed			_							24a. Was autor	osy	pr	ior to co	ppsy findings a mpletion of car	
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Hosp 24 hou Fune rtely fi	9	20a Certifier	ying Physic	cian: To the best	of my knowl	edge, death o	ccurred	at the time, o	date and	place, and	due to the cau:	se(s) a	nd manner a	as stated	ı.	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	edical	one) 2 Medic	al Examine	er:On the basis of and manner st		n and/or invest	tigation	, in my opinio	n, death	occurred a	at the time, date	and pl	ace, and du	e to the	cause(s)	
	ž	29b. Signature and title of	certifier					29c. Licen		er		29d.	. Date signe	d (Mont	h, Day, Year)	
and								0.0	.M.E.			Apı	ril 20, 200	07		
		30. Name and address of					n Ct	not Baltim	oro NA	D 2420	1					
S	ate	Ana Rubio MD. 31. Date filed (Month, Day		ant Medical E	gistrar's Sign		ii otre	eet, Baltim	iore, M	D 2 120	1					
Regist			0 3 20		ر معدنگ	B A	154									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 07 OPe /Medical 4c. County of Death 4b. City. Town, or Location of Death Facility Name (If not institution, give street and number) Examiner timore NA Wary and MET If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3-27-2007 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Social Security Number Days **Funeral** 1 XM 2 ☐ F 220-77-3118 Md. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Yes 2 No Director Md. Baltimore NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 517 Chestnut Hill Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give Year or Dates: 1 Never Married 2 Married filed within 72 hours after Specify: Black 1 ☐ Yes 2 XNo Saltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Infant NA Infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event. Be Maia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21218 28th Street, Baltimore, 339 E. Kim Tate Aunt Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) 5-4-07 Md Lansdowne, Zion Cem. 22. Name and Address of Facility F.H. East March 21. Signature of Funeral Service Licensee 21202 Md. Baltimore, 1101 E. North Ave., la wan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MOX disease or condition resulting in death) Due to (or as a consequence of) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that the death certificate be executed that initiated event. and resulting in death) Last Due to (or as a consequence of): physician a Box 68760, Physician/Medical attending ph for use as ti IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 5 ☐ Other (specify) 4□Pregnant at time of death 1 ☐ Yes 2 ☐ No P.0. been signed by the should be detached 9☐Unknown 9 T Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 2 No 3 Probably 4 ☐ Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe has 21110 1∐ Yes this certificate al or Attending Physician: s after death.
al Director: After this certifica ed in by the funeral director, p 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours a To the Funeral I Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 31. Date filed (Month, Day,

reene

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

82. Registrar's Signature

7-03281			or Print in Black					ible.	
onnie T. Plateo		State I- For State	e of Maryland / Dep			Mental Hy	ygiene	20	07 1100
		Registrar		ertificate	of Death			g. No. 4 U	01 . 165
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		4a. Facility Name (if not institution, o	ive street and number)		4b. City, Town, or Lo			4c. County of Dea	ath
		University Hospital			Baltimore City	У			
Funeral		Social Security Number 6.	Sex 7. Age (In yrs	s. last birthday)		If Under 24Hrs	. 8. Date of Birth	(MM/DD/YYYY) 9. E	
Director	- 1	213-96-0364	X M 2 F 36	;	Months Days	Hours Min.	03 0		eign Country) MD
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5-0036 led within 7 Hygiene. other than the Medica	Ē	12th grade	na	TOM	Truck Dri				TOWING CO
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be fi	8	Johnny L. Pla	teo Sr.			-	Bennett		
21 hould hould is man	٩	19a. Informant's Name/Relationship	, ,		ling Address (Street a				
MD d 2 sho lth and n 27 is		Joyce Hunter-			Hillvale				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1X X Burial 2 Cremation	3 Removal from State		position (Name of ceme other place)	etery,	Date	20c. Location - City	or Town, State
Baltimore, permit. Pages I ar Department of Hes Important: If ite	П	4 Donation 5 Other Spec	Kemovai irom state		morial Pa	ark 5/	4/07	Randalls	stown, Md
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e Ho 124 } e Fui etely		(Oriotal Orin)	ician: To the best of my knowl	-		•			
To the Hos within 24 h Fo the Fun completely	Medical		r:On the basis of examinatio and manner stated.	n and/or invest	· · · · · · · · · · · · · · · · · · ·		at the time, date a		
	ž	29b. Signature and title of certifier	-		29c. License	number		29d. Date signed (#	Month, Day, Year)
		- // /			O.C.M	.E.		April 30, 2007	
→ 1.		30. Name and dress of person wh	o completed cause of death (I	tem 23a)					
\mathcal{S}	5 8		eputy Chief Medical Ex		111 Penn Street,	Baltimore, M	1D 21201		
Si	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sigr	noti iro	* *			· · · · · · · · · · · · · · · · · · ·	
Regist		MAY 0 3	2007 Marie	A. A.	200KL)				
			4	- 1					

07-03281

			1 - For Amend #19a	Per ANA	of Maryl BD G867	and / Depa 7 5/14ტე	artment of I Ttificate of	lealth a <i>Death</i>	nd Mental	Hygiene Reg. No	2007	14293
	Physici	an ,	1. Decedent's Name (First, Midd						2. Date of Month		ž6, 288	3. Time of Death
	/Medio		Nancy Scott 4a. Facility Name (If not institution	on, give street and	number)		4b. City, Town, o	or Location of	Death		County of Deat	th .
	ZAGIIII		Saint Jose	<u>'</u>		enter			wson		Bal	timore
	Funeral Director		5. Social Security Number 214-26-7719	6. Sex 1 ☐ M 21 ☐ F		yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2	Min. (Montl	of Birth h, Day, Year) 28, 19	Co	hplace (State or Foreign untry) ryland
	land ow tt		Usual Residence of Decedent 10a. State 10b. County	/	10c.	City, Town or Lo	ecation					10d. Inside City Limits
	a-f sh	ctor	MD Balt	imore		Tow	son					1 □Yes 2▼ No
	3a or 28 st be no	al Dire	10e. Street and Number 800 Southerly	Road #9	12		10f. Zip Code 2	1286		10g. Cit	izen of What Co USA	untry?
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mar 3 ☑ Widowed 4 □ Divorce	rried Armed	ecedent Ever in Forces? s 2 1 No Give r Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No	Hispanic Origi an, Mexican, Specify:	in? (Specify Yes o Puerto Rican, etc	or No-	14. Race - Ame Black, White Specify: W	
212-0030	nin 72 hou n "natura Medical E	Completed	15. Decede (Specify only higher Elementary/Secondary (0-12)	<u> </u>	ed) e (1-4or 5+)	ı (Give	dent's Usual Occu kind of work done DO NOT use retire	during most of	of working	16b. K	ind of Business/	Industry
7	ed with ygiene ier tha t, the	Com	12	5-1		guid	ance cou				ducatio	n
ylalid	d be fill ental H ced oth c even	Be	17. Father's Name (First, Middle Townsend Scot:						s Name <i>(First, Mi</i> ancy Guf		Surname)	
ar y	shoul and Mi s mark	2	19a. Informant's Name/Relation				ng Address (Street	and Number	or Rural Route N	umber, City o		Zip Code)
Σ Σ	1 and 2 Health tem 27 i		Nancy Parvis Mary L. Parvi 20a. Method of Disposition	/daughter <mark>s /daugh</mark>	ter 20	b. Place of Dispo	Anneslie		Baltimor		21212 ocation - City or	Town. State
Dailtimor	Pages Iment of tant: If it jury or o		1 ☐ Burial 2 ☐ Cremation 4 🖾 Donation 5 ☐ Other (3 □Removal fro Specify)	om State		matory or other pla					
סמ	permit Depar Impor any In once.		21. Signature of Funeral Cervice Ronal d	S. Wade	Direct		Name and Addre tate Anat altimore.	_		W. Bal	ltimore	Street
١			231. Part1. Enter the disease, of shock or heart failure. Lis	or con plications that t only one cause o	at caused the d n each line.					ory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	d	CHEMIC to (or as a cons		OMYOPAT	HY				Choot and Deam
	Examiner	_	Sequentially list conditions,	b	to for as a cons	eo wioneo offi						
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	6	10 OI a3 a COII.	se pence on						
0/00,	icate be executed physician and s the burial-transit	dical Ex	resulting in death) Last	Due	to (or as a cons	sequence of):						
	rtificate ng phys as the	0	IF FEMALE:	0.								
O. DOX	To the Hospital or Attending Physician: The law requires that the death certifi To thin 24 hours after death. To thin 24 hours after death. Completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Liv	outcome pf pre e birth 2 DF egnant at time known	etal death 3]Ectopic pregnanc] Other (specify) _	у		_	23d. Date of deli Month	ivery Day Year
Ů,	es that i gned by be deta	by Ph	Part II. Other significant condit	-		resulting in the u	nderlying cause giv	ren in Part I.	23e. I	Did tobacco u	use contribute to	the cause of death?
COLCO,	v requir been s should	eted	CHRONIC R	ENAL FAL	LURE			<u></u>	_			obably 4 Unknown
בי ה ה	The law cate has I	Completed							—	Was an autopsy performed? es 2 KNo	prior to death?	topsy findings available completion of cause of 2 No
N I C	slcian certifi rector	Be	25. Was case referred to medica examiner?	Hospital:			. 3 DOA Oth	or:	of Death (Check o			
5	ilng Phys After this funeral di	ion: To	1 ☐ Yes 2 No 27. Manner of Death 12 Natural 5 ☐ Pendi	28a. Da	Inpatient 2 te of Injury onth, Day Year	2 ER/Outpatien 28b. Time of Injury	28c. Inju	4 Li Nurs ry at rk?		Residence ribe how injui		cify)
201717	or Attendater death Director: in by the	Certification:	2 Accident invest 3 Suicide 6 Could 4 Homicide deterr	ningd 286. Pla	ace of injury - A ilding, etc. (Spe	t home, farm, streecify)	eet, factory, office	Yes 2 □ No	28f. Locati	on (Street an Town, State		ıral Route Number,
	Hospital 24 hours Funeral stely filled	edical Co	29a. Certifier (Check only one) 1 Certifyi 2 Medical	ng Physician: To	the best of my basis of exam anner stated.	knowledge, death	n occurred at the ti vestigation, in my	me, date and opinion, death	place, and due to n occurred at the t	the cause(s) and manner as d place, and due	stated. to the cause(s)
	To the within To the Comple	Mec	29b. Signature and title of certifie	P)	1		29c. Licens	e number		29d. Da	te signed (Month	h, Day, Year)
			1 Ja Jung 2	1 m	ella	m.0	D41	410		APRI	L 271h,	207.
			30. Name and address of person JOGINDER F.	who completed ca	ause of death (I		Print) OSLER D	RTUE	TUMEUN	MARY	YLAND	21204
	Sta	- 1	31. Date filed (Month, Day, Year,) 32	. Registrar's Si		and the last 15 Ad	r t ob V kos	* msammidi	1717111	r loc (**1144.4*	here she from Mark ""P
	Registr	ar	MAY 0	3 2007 3	2. 20 16.45 5	Sie Si	Will Bern					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. Decedent's Name (First, Middle, ast) 2 Date of Death MYCL **Physician** enr /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner Gener (ounis Howard columbia 1+0w If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 M 90 Director 242-92-6687 01/02/1917 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show injury or other traumatic event, the Medical Examiner must be notified at 1. Yes 2 No Director Ellicott_City MD Howard -28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 4077 Fragile Sail Way 21042 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married or i 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify. Specify: þ 3 Widowed 4 □ Divorced Black "natural" Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Own Home Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Edward Gibson Minnie Johnston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Penn/Daughter 4077 Fragile Sail Way Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State May Chesapeake Crematory Inc. 2007 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. De not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 Tyes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

Signal

30-Name and address of person who completed cause of death (Item 23a) (Type, Prot) 5005 579 mail Se

Il Cane Clarisille MD 21029

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** apri. 1.05 THEL -cper 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deat 4b. City, Town, or Location of Death Examiner Rehabilitation Contor Columbia Howard crien If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day Year July 18, 1939 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days 1 □ M 2 🔀 F Maryland 216-36-5501 67 Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Hygiene. Sther than "naturel", or iteme 23a or 28a-f ehow ent, the Mudical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 USA 622 Regatta Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: 2 Specify: white 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Household Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eslein Ha 11 Thelma Harry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7837 Outing Ave. Pasadena MD 21122 Karen Tarleton daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Depertment of importent: if eny injury or goot. 5/3/07 Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Stallings Funeral Home P.A. 3111 Mountain Road Pasadena MD 21122 disease 23a. Part . Enter the s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart fature. Immediate Cause (Final **Physician** Carebrougscular disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ntra crania hemurrhall Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit 1) ypertension Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by artery disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 1 ☐ Yes Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Other: 41 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral dir 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DCC22483 april 30,200) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) l A. Glen Burnie, MD lacchs mo 30S DOEDITA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 03 2007 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician REYEL 5.00 5 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE BALTIMORE 4209 SPRNGBALE AUE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 \ E 213-40-8878 64 0-9-174 PA Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10c. City, Town or Location 10b. County пs 23a or 28a-f shov must be notified at 1 ☐ Yes 2 No Baltimore Director MD Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 4209 Springdale Avenue 21207 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, Items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or Item Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other than "natu 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Manager Church 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Ith and Mental H
77 is marked otl
77 traumatic ever Be Thomas Priolo Edna Bealer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau once. 7124 Forest Avenue Hanover MD. 21076 Mr. Thomas Reyer / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Hand Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mav 2007 5 ☐ Other (Specify) Owings Mills, MD Garrison Forest Cem 22. Name and Address of Facility Singleton Funeral Home, P.A. 21. Signature Funer Second Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DAY CONGESTINE HEART FAILURY /Medical Due to (or as a consequence of): Examiner TRACT Z 0445 URINARY Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed in 34 hours after about Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 211-NO 1 🗌 Yes 3 Probably 4 Unknown ARTERY DISSASE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an SIABETE autopsy performa 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation s after deam.
ral Director; Aftr 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a centifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

10

DHMH 17 Rev 1/2001

7801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAY 0 3

32 Registrar's Signature

050216

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Month RIDENOUR ANTHONY

State of Maryland / Department of Health and Mental Hygiene 2. Date of Death 3. Time of Death Day Year **Physician** 2:02 PM APRIL 30 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A BALTIMORE OF (ENTEX MARYLAND MED | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March | 25, 1968 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral XX** M 2□ F 214-68-2705 39 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State N/A MD BAltimore XXYes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3126 Keswick Road 21211 U.S.A. 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2XXNo

16a. Decedent's Usual Occupation

Specify.

XX Never Married 2 Married 3 Widowed 4 Divorced

mpleted by Funeral

"natural", or items 23a or 28a-f show edical Examiner must be notified at

and Mental Hygiene.

Is marked other than "natural aumatic event, the Medical permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg important: If item 27 is marked other any injury or other traumatic event, I

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

sician and burial-transit he law requires that the death certificate be executed attending physician for use as the buria pege 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A
completely filled in by the f

Division or Vital Records, P.O. Box 68760,

Compl	Elementary/Secondary (0-12)	College (1-4or 5+)	N/A	9d)		N/A	
To Be Co	17. Father's Name (First, Middle, Last)	Floyd Ride	nour	18. Mother's Name Linda	(First, Middle, Shaffe)	•	
	19a. Informant's Name/Relationship (7 Linda Ridenour (N	Type. Print) Mother)	19b. Mailing Address (Stree 3126 Keswick	Road Balt	Route Numbe	er, City or Town, State, 2 21211	Zip Code)
	20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Met	Place of Disposition (Name of the emetery, crematory or other place of Crematory	^D 5/2/	ate 2007	20c. Location - City or Catonsville	•
	21. Sign to defuneral Service Liter	arpentu	22. Name and Addr Burgee-He 3631 Fall	ess of Facility nss-Seitz s Road Ba	Funeral lto, M	Home Inc	•
	23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused the death one tause on each line.	h. Do not enter the mode of dy				Approximate Interval Betw Onset and Do
		Due to (or as a consequence of the consequence of t	PITIS				3 DAY
I Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	C. ACMUNES / Due to (or as a conseq	uence of): DEFIC uence of):	IENCY SY	,~010	ne	YEARS
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome pf pregna 1 Live birth 2 Feta 4 Pregnant at time of d	al death 3 ☐ Ectopic pregnan			23d. Date of de Month	livery Day Y
ed by Ph	Part II. Other significant conditions of	- ,				obacco use contribute to	
Complet	HERATTIS C				24a. Was auto perfo	an 24b. Were a prior to death? 2 \(\begin{array}{cccc} 2 & No & 1 \end{array}	utopsy findings a completion of ca
Be	25. Was case referred to medical examiner?	Hospital:		26. Place of Death		,	
Certification: To	1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury 28c. Inj	4 Li Nursing Hor		dence 6 □Other (Spe how injury occurred	ecify)
ertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, factory, office fy)	9 2	8f. Location (City or To	Street and Number or R wn, State)	ural Route Numb
lical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exar	nysician: To the best of my kno niner: On the basis of examina	owledge, death occurred at the ation and/or investigation, in my	time, date and place, a opinion, death occurr	and due to the ed at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)

1 Yes 22 No If Yes, Give Year or Dates:

15. Decedent's Education (Specify only highest grade completed)

(Give kind of work done d life DO NOT use retired) N/A	uring most of wo	orking	ŀ	/A	industry
	18. Mother's Na	me (First, Middle	, Maide	en Surname)	
r	Linda	a Shaffe	r		
b. Mailing Address (Street a 1126 Keswick 1	nd Number or R Road Ba	lural Route Numb Lto, MD	er, City 21	or Town, State, 2 211	Zip Code)
of Disposition (Name of	2)	Date	20c.	Location - City or	Town, State
ery, crematory or other place Crematory	5/2	2/2007	Cat	tonsville	e, MD
22. Name and Addres Burgee—Hens 3631 Falls	ss-Seitz	z Funera Balto, M	l Hç	ome, Inc.	
not enter the mode of dying			rrest,		Approximate Interval Between Onset and Death
of):					3 DAYS
of): une DEFICI	ENCY	Synono	me		YEARS
of):					
				23d. Date of de	ivery

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Year

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Black, White, etc.

White

Specify:

16b. Kind of Business/Industry

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 17385 M.D 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) CENTER RONALD ESURI MED LINIV 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

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DHMH 17 Rev 1/2001

7-03246 Garri

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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The control of the co	ie W. Roberts		or State	Cer	tificate of D	eath			Reg. No.		3. Time of	Death
The control of Lens Section of Lens Section (Lens Section Sect	Physician/		strar recedent's Name (First, Middle,Last)	Garrie Wayne Rob	erts			Month	Day	Year		
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TOTAL TOTAL				street and number)			Callott of Bot	uu i	1	N	1A	
5. Source Security Number 1. Security Supplied (Security Supplied (Se			2721 W. Mosher Street				If I Indos 24h	Hre 8 Date of F	Birth (MM/I	OD/YYYY) 9.	Birthplace (Sta	te or
The State of the S	Funeral	5.	Social Security Number 6. Sec	7. Age (In yrs. la					10	l i - or	reian	
The control of the co		12		M 2 F		VIOLITIS		JAN.	17,1	1933	Country	ia.
The street are shared as the street of the s		0									10d Insid	e City Limits
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Visit Visi	the day		2721 W. M.	13 HER 31.	10 10 100	locadent of Hish	anic Origin?	(Specify Yes or	No-			, Black,
Vivo 2 New Park Vivo	with be n	11		Armed Forces?	If Yes,	specify Cuban,	Mexican, Pu	erto Rican, etc.)	l	White, et	C.	
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296. Signature and the of consists. O.C.M.E. April 29, 2007 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State Registrar 12. Registrar's Signature Registrar 13. Date filed (Month, Day, Year)	that deta	<u>م</u>						1	Yes			
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Margarita Korell MD. Assistant Medical Examiner 111 Periff Street, Baltimore, ND 2125. State Registrar 31. Date filed (Month, Day, Year) Registrar 12. Registrar's Signature			Mounte D	nel March		0.	U.IVI.E.			, .p 20, 2		
Margarita Korell MD. Assistant Medical Examiner 111 Periff Street, Baltimore, ND 21231. State Registrar 31. Date filed (Month, Day, Year) Registrar 12007		1	30 Name and address of person	who completed cause of death	(Item 23a)							
State Registrar 3 2007 Registrar's Signature				Assistant Medical Ex	aminer 111	Penn Street,	, Baltimor	e, MD 21201				
Registrar MAY 0 3 2007		_	Od Data filed (Marth Day Year)									
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			1 = For State Registrar	State of Maryland			of Health a of Death		tal Hy	giene () Reg. No.	07	142	99
,	X W		1. Decedent's Name (First, Middle, Last)						Date of De	ath Day	Year	3. Time o	f Death
1	Physici Medio/		Rise Jean Sheridan	-Peters				Ma	_	, 200		8:10	РМ
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, To	wn, or Location of	of Death		4c. Cou	nty of Death	1	
A		Ă.	4904 Sundown Circl	e		Bowie					ce Geo	orges	
	Funeral		Social Security Number 6. Security Number	144 or V-		If Under 1 Y Months D	rear If Under Pays Hours	24 Hrs. 8. (Date of Bir Month, Da	14 196	9. Birth Cou	place (State intry)	-
	Director		230-08-8844	46	Yrs.			A	pril	14 196)	rginia	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation						10d. Inside C	ity Limits
	Mary	ō	MD Prince Ge	eorge's Bow	ri e							1 🗌 Yes	2 X No
	28a	rec	10e. Street and Number	20186 8 1 201	110	10f. Zip Co	ode			10g. Citizen	of What Cou	untry?	
	72 hours after death with the Maryland natural', or Itams 23a or 28a-f ehow Jical Examinar must be nutlied at	Funeral Director	4904 Sundown Circ	Α		2072	20			T	ISA		
	ms 2	Jera	11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?		Was Deceden	t of Hispanic Ori	igin? (Specify	Yes or No)- 14. F	Race - Amer		
9	or Ita		1 ☐ Never Married 2 ☒ Married	1 ☐ Yes 2 XNo If Yes, Give		i res, specily 1 □ Yes 2 🗷	Cuban, Mexicar No Specify:		iii, 0 (0.)	1	Black, White		
5-0036	ral',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		10163 22	140 Specify.			Зрв	cify: Wh	ite	
5-0	72 h 'natu	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual C kind of work o	done durina mos	t of working		16b. Kind or	f Business/I	ndustry	
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12	led v tygie her t		17. Father's Name (First, Middle, Last)	JT	Lawye	3L	18 Moths	ar's Name /Fi	ret Middle	, Maiden Sun			
anc	he find he fin	Be	James A. Peter	*G				bara	Com		,amo,		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Itams 23a or 28a-1 ehow other traumatic event, the Madical Examinat must be nullised at	2	19a. Informant's Name/Relationship (Ty		19h Maulio	a Address /S	treet and Numbe		0011		wn State 7	in Code)	
Ma	d 2 si th an 7 is r		James Sheridan-Pet				m Circl					<i>p</i> 0000)	
	ges 1 and t of Health if Item 27 or other tr		20a. Method of Disposition	20b. Pi	lace of Dispo	sition (Name	of	Date Dow	ie, r	20c. Locatio		Town, State	
õ	Pages nent of int: if Its		1 Burial 2 Cremation 3 F	emoval from State	emetery, crer Co. Coc	•	r place)	5/3/20	07	Bolt:	more,	MT	
Baltimore,			4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens						-			ги	
Ba	permit. Departr Imports any nji		21. Signature of Funeral Service Licens	Dring	100	Cremat	Address of Facility Ion Soc Sederick	iety o	f Mai	ryland,	Inc.	21228	
4 9			23a. Part1. Enter the dis lase, or complishock, or heart failule. List only or	cations that caused the death	n. Do not ent						rno	Approxima	
- 22			Immediate Cause (Final									Interval Be Onset and	Death
	Physician /Medical		disease or condition resulting in death)	Liver Fa								1 mont	h
a.	Examiner			Metastat		east Ca	ncer					2 year	8
		je	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ		.450 00	ineer					7	
A	outed d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
7,	cate be executed physician and the burial-transit	Exa	resulting in death) Last	Due to (or as a consequ	uence of):								
8760,	te be ysicia ne bu	dical		f									
9	certifica nding ph use as th	0	IF FEMALE:								13.1		
XO	eath certific attending pl for use as t	ar/	23b. Was decedent pregnant	3c. If yes, outcome of pregna 1☐Live birth 2☐Fetal		Ectopic pregi	nancy				Date of deli	,	Year
). B	0 00	sici	in the past 12 months? 1 □ Yes 2 🕱 No	4☐Pregnant at time of de 9☐ Unknown	eath 5	Other (speci	ify)				Month	Day	r oai
P.0	requires that the de een signed by the a nould be detached f	Physician/M	9 Unknown		100				00- 0:4			Ab =	desah O
s,	res th	5	Part II. Other significant conditions con	ithouting to death but not rest	alling in the u	ndenying caus	se given in Part i			tobacco use c Yes 2 XNo		bably 4	
Records,	w requir been si should	Completed							-				
ec	The law ite has b page 2 st	d d							24a. Was auto	psy	prior to c	topsy findings ompletion of	available cause of
=	(g LL	ပ္ပ							1 Yes	ormed? 2 No	death?	2 No	
Vital	iician: The lav certificate has rector, page 2	Be	25. Was case referred to medical examiner?	localtal:			Othon	e of Death (C					
of	ding Physician: After this certific funeral director,	မှ	TE Tes 2		ER/Outpatier		J			dence 6 🗆		eify)	
u C		lo	27 Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28C	. Injury at Work? 1 ☐ Yes 2 ☐		Describe	how injury oc	curred		
isic	Attending r death. octor: After	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	omo farm etr				Location	Street and Nu	mher or Ru	ral Route Nur	mher
Division	or A after Direct in by	Certification:	4 Homicide determined	building, etc. (Specify	/)	eet, lactory, o	illo	20		wп, State)			11007
_	Hospital		29a. Certifier 1 Certifying Phy	sician: To the best of my know	wledge, death	occurred at	the time, date an	nd place, and	due to the	cause(s) and	manner as	stated.	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edicai	(Check only 2 Medical Exami	ner: On the basis of examinal and manner stated.	tion and/or in	vestigation, in	my opinion, dea	ath occurred a	t the time,	date and place	ce, and due	to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1		29c. L	icense number			29d. Date sig	ned (Monti	n, Day, Year)	
	. > - 0		Je M	/Sen Il			35996			5/3/	2007		
-	10		30. Name and address of person who co	om eted cause of death (Item	1 23a) (Type,	-	JJJJ0			5,51	2007		
	·To	1	Linda Burroll MI	2730 Univer	city D	1.77	#4.00 T.T	haatan	M	20002			

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 2007 9:30PM May Helen I. Sunderland /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Heartlands Ellicott City Howard 8. Date of Birth Month, Day, Feb 6, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1905 1 □ M 2 💢 F 102 219-20-5930 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 XNo if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f shother traumatic event, the Medical Examiner must be notified Director Ellicott City Maryland Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 21043 USA 3004 North Ridge Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Ijams Lee J. Linthicum ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Lookout Point Berlin, Maryland 21811 James E. Sunderland,Jr., Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot 1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 05/04/07 Woodlawn, Maryland 21. Signaturg of Funeral Service see ²²MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATHEROSELEMENC CARDIOVASCUCAL SETIMS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transi that initiated events resulting in death) Last and Hospital or Attending Physician: The law requires that the death certificate be exected hours after death.

Funeral Director: After this certificate has been signed by the attending physician antalejing in by the funeral director, page 2 should be detached for use as the burial-trace. Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D51860

State Registrar 30. Name and address

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

10700 CHARTER DAINE

200

COLUMBIA MO 2/644

of person who completed cause of death (Item 23a) (Type, Print)

MD

Registrar's Signature

FISH

JONATHAN

			Please	Type or Prin					-		egible.		
		1 - For State Registrar		State of Ma	ai yiai ic		tificate of l			eg. No	007	1430	
Dhusia		1. Decedent's Nam	e (First, Middle, La	ast)					2. Date of Dea Month	th Day	Year	3. Time of Dea	
Physic /Med		Agnes	Marie						April	27,	2007	10:00 f	, W
Exami	iner	4a. Facility Name (_	ve street and number)			_	Location of Death			ounty of Death		
Funera		5. Social Security N		Sex 7. Ag	e (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			nplace (State or Fountry)	oreign
Director		220-38	- 5843	1□M 2 ⊠ F	66	Yrs.	Months Days	Hours Min.	(Month, Day January 21			unity)	
pui »		Usual Residence o	f Decedent 10b. County		10c, City.	Town or Loc	cation			*		10d. Inside City Li	imits
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s afte	by F	1 ☐ Never Mar	ried 2 Married	1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:	No	1	I∐Yes 2⊠Mo	Specify:		s	pecify: W	hite	
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Dallinor Dermit Pages Department of mportant: If it any injury or o		4 Donation	5 ☐ Other (Spec	city)	Ana	tomy Gi	fts Begiste	y April 2	8,2007	Han	over, 1	MD	
DESILITIOTE, INIGITY IGILIA ZIZIO-UUJO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at any night.	Š	21. Signature of 5	uneral Service Lic	ensee		22	2. Name and Addre	ss of Facility An	atomy Gi	445 BE	egistry	71071	
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vergives that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	EXa	resulting in death)	Last	Due to (or as	a consequ	ence of):							
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Or VITAI Physician: This certifica	o Be	examiner?		Hospital: 1 ☐ Inpati	ent 2 🔲 I	ER/Outpatier	nt 3 DOA Oth		ath <i>(Check only o</i> Home 5□ Resid		☑ Other <i>(Spe</i>	cify) HOSPI	rF.
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VISION Attending r death. ector: After by the fune	atio	1 Natural 2 Accident	5 ☐ Pending investigati	on			M 1□	Yes 2 ☐ No					
DIVISION I or Attending after death. Director: Afte	Certification:	3 ☐ Suicide 4 ☐ Homicide	dotormino		jury - At ho tc. <i>(Specif</i>)	me, farm, str	reet, factory, office		28f. Location (S City or Tow		Number or Re	ural Route Numbei	r,
To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical Ce	29a. Certifier (Check only	1 X Certifying 2 Medical Ex	Physician: To the best aminer: On the basis of	of examinat	wledge, deat tion and/or in	h occurred at the ti	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) a date and p	and manner as place, and due	s stated. e to the cause(s)	
o the lithin 2 or the loop the loop the loop	Med	one) 29b. Signature an	d title of certifier	and manner st	.ated.		29c. Licens			29d. Date	signed (Mont	th, Day, Year)	
FSFS		•	/-				D	4372		٤	4/30/	67	
1		30. Name and ad	dress of person wh	no completed cause of	death (Item	23a) (Type,					1		
,		01 m 1 ft 1/44	IQ MAHMO	32 Romiet	rar's Signa	ture	EY RD.	rimonium,	MD 2109	93			
Regi	State strar		MAY 0 3	2007	we.	K A	bert						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

AMEND TITEM#20b, perfff, G867, 5,00007, WS

State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Marie Sells Rosa 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death County of Death Examiner Franklin Dauare If Under 1 Yea Months Days Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Social Security Number Abe (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 😿 F Director 043-58-4454 63 12-28-1943 Va Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No **Funeral Director** Harford Edgewood Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21040 USA 1805 Harbinger Trail 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 No Res, Give ear or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gertrude Gregory Unkn ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1805 Harbinger Trail, Edgewood, Md. 21040 David L. Sells Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 15 Burial 2 □ Cremation 3 □ Removal from State 41 Donation 5 □ Other (Specify) Garrison Forest Vet. 5 07 Owings Mills, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F.H. East l adip wan Baltimore, Md. 21202 1101 Ε. North Ave., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical o (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (of as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) ed by the a detached t 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 TYes 2∏ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe 21 No 1☐ Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital The ritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 호 29c. License number 29d. Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print) Name and 32 Registrar's Signature State 31. Date filed Month, Dav. Year, Registrar MAY 03 2007

DHMH 17 Rev 1/2001

07-03279 Leroy Saunders Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Registrar	Reg.	No.								
Physicia	an/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year 2.210 brs										
ledical Exami		Leroy Sanders A	pril 29, 200	7								
1		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital 4b. City, Town, or Location of Death Baltimore City		4c. County of Deat	h							
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with the Maryland ns 23a or 28a-f sho be notified at once.	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Cou	untry?							
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-00 d wit ygien other	Son	17. Father's Name (First, Middle, Last) 18. Mother's Name (Fir	rst, Middle, Mai	iden Surname)								
21215-0036 suld be filed within 7 Mental Hygiene. marked other than	Be (Lerov Michael Sanders, Jr. Geraldi	ne	Car								
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once	짇	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	Route Number	er, City or Town, Stat	te, Zip Code) 212 more, Md.							
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Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mar 1101 E. North Av	ch F.	H. East								
0 8 9 7 7 18		M lady Warre 1101 E. North Av	e.,	Balti	more 21202							
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Examiner	15	Immediate Cause (Final disease a. Multiple Gunshot Wounds			Death							
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b.O. that the red by detacl	by F	Contributing to death but not resulting in the underlying cause given in Fact.		2 ✓ No 3 Pr								
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Division of Vital Records, P.O. Box 68760, To the Hospinal or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the	ne time, date ar	nd place, and due to	the cause(s)							
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		O.C.M.E.		April 30, 2007								
		30. Name and address of erson and complete cause of death (Item 23a)										
4		Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD	21201									
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		· · ·								
Regi	strai	MAY 0 3 2007 Mayer D. James										

			For State Registrar		State of Ma	arylan		artment rtificate			nd Men		giene Reg. No	200	7	14301
		-	Decedent's Name	(First, Middle, Las	st)							Date of De	eath			Time of Death
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	Examir				e street and number)					ocation of	Death		40	. County of D	eath	
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	Funeral		5. Social Security No	. 1	ex ∏M 2□F 7.Ag	, ,	last birthday) 56 Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min. 8.	Date of Bir Month, Da	ay, Year,)	Birthplace Country)	(State or Foreign
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	/land ow		10a. State	10b. County		10c. City	y, Town or Lo	cation							10d. li	nside City Limits
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	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Funeral Director	11. Marital Status		12. Was Decedent Armed Forces?		.S. 13.	Was Decede If Yes, speci	ent of His fy Cuban	panic Orig , Mexican,	in? (Specify , Puerto Rica	Yes or No an, etc.)	0~	14. Race - A Black, W	merican In /hite, etc.	idian,
36	s afte	by F	1 Never Marri	ed 2 Married	1 ☐ Yes 2 ☐ I If Yes, Give Year or Dates:	No		1 ☐ Yes 2	ĘkNo	Specify:				Specify:	Bla	ck
E 00	hour ntural	8	O LI Madined	15. Decedent's Ed			16a. Dece	dent's Usual	Occupat	tion			16b. h	Kind of Busine		
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20	d with giene er tha	ĕ	•	* ' '		,,,	Sa	nitat	ion				В	altim	ore	City
7. Pd	e file al Hy fothe	Be (7th gra 17. Father's Name (First, Middle, Last,)	_					•	rst, Middle	, Maide	n Surname)		
7 Vla	Ment Ment arked	2	James			S	ampso				lna ———			Bet		
2007 7: Maryland	2 sh and Ism raum		19a. Informant's Na					-						or Town, Star More,		^(⊕) 21213
	1 and Health		20a. Method of Disp	7 Sampso	on Wif						Date		-	ocation - City		
RIL 30, Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.]Removal from State		Place of Dispo cemetery, cre			1						
프	artme ortani injun		21. Signature of Fu			Ki	ng Me	m . Pl	Address		<u>-5-0</u>			andal		wn, Md.
APRIL Balti	permir Depar Impor any ir		▶ ∆ .	la du	o Wo	1 . 0 -	$\supset $	1101	Ε.	Nort	na: h Av	rcn e.,	г.н Bal	. Eas	c e, M	d. 2120
4	-#		23a. Part1. Enter th	ne disease, or com	plications that caused one cause on each li	the deat	h. Do not en								Apr	oroximate erval Between
	Physician		Immediate Cause (Final	LUNG CAL										Ön	set and Death
	/Medical		resulting in death)		Due to (or as		uence of):									
	Examiner		Sequentially list cor	nditions	b											
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	The law requires that the death certificate be executed, the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) L	ast	c Due to (or as	a consen	mence of).								-	
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387	physicate physicate	Completed by Physician/Medical			d											
Box 6	leath certific attending p	N/C	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome	pf <u>pr</u> egna	ancy	_						23d. Date of	delivery	
ă	death atter	cial	in the past 12	months?	1 ☐Live birth 4 ☐Pregnant a			□Ectopic pre □Other <i>(spe</i>						Month	Day	Year
_ 0	ilclan: The law requires that the decentificate has been signed by the rector, page 2 should be detached	hys	9 ☐ Unknown		9□Unknown											
SAMPSON scords, P	ss tha	y P	Part II. Other signif	lcant conditions	contributing to death b	ut not res	ulting in the u	inderlying ca	use give	n in Part I.						ause of death?
SAMPS(ecords,	en sig	ed	ļ 								- 1	1 🗌	Yes :	2 □ No 3 □] Probably 	4 VUnknown
w	law ras be	plet]	24a. Was	psy	prior	to comple	findings available
2 4		Som										perf 1□ Yes	formed? 2 X IN] No
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E P	Shysi this c	은	1 ☐ Yes 2 X 27. Manner of Deat		Hospital: 1 ☐ Inpation		ER/Outpatie			4 🗆 1401	1			6 X Other (ury occurred	Specify)	HOSPICE
	ding l	Certification:	1 🔀 Natural	5 Pending investigatio	(Month, Da	y Year)	Injury	M 2	Bc. Injury Work' 1 ⊟ Y	? ′es 2 ∐ 1		. Describe	TIOW III	ury occurred		
<u></u>	vtending death. ctor: After	icat	2 ☐ Accident 3 ☐ Suicide	6 Could not b	e 28e. Place of inj	jury - At h	ome, farm, st				-			and Number o	r Rural Ro	ute Number,
Division	after Dire	ertil	4 Homicide	determined	building, ei	tc.' (Specil	fy)					City or To	own, Sta	ite)		
a -	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	a C	29a. Certifier	1 Certifying P	hysician: To the best	of my kno	owledge, dea	th occurred	at the tim	e, date an	d place, and	due to the	e cause((s) and manne	er as stated	d.
(2)	he Ho nn 24 I he Fu pletel	edical	(Check only one)	2 Medical Exa	miner: On the basis of and manner st		ation and/or i				un occurred	at the time				
	To t	Σ	29b. Signature and	title of certifier				290	License	number			29d. D	ate signed (A	fonth, Day	, Year)
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	Ct.	ate	DR. TAI	RIQ MAHMO	OD 2300 I 32 Regist	rar's Signa	IEY VAI	LEY R	υ	1 TWON	IIUM,	MD 21	.093			
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			1 - State of Ma Registrar	ryland /	-	rtment of F tificate of				giene Reg. No	2007	14305
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Jeanette Bertha Schaffer						Date of De Month pril 2	Da	2007 Year	3. Time of Death 11:55 P M
	Examin Funeral Director		502-03-1999 ^{1□ M 2} X F 90	(In yrs. last b	oirthday) Yrs.	4b. City, Town, or Rockvil If Under 1 Year Months Days	1e	er 24 Hrs. 8	Date of Birl (Month, Da	M M	ontgomer: 9. Birth Cou	y place (State or Foreign
	saryland show ed at	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, To								10d. Inside City Limits 1 1 Yes 2 □ No
	h with the N 3a or 28a-f st be notifie	al Director	Maryland Montgomery 10e. Street and Number 9701 Viers Drive	Rockv	<u>ille</u>	10f. Zip Code 20850				10g. Ci	tizen of What Cou	
36	's after deat '', or Items (by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cub ☐ Yes 2 X No			fy Yes or No can, etc.)	-	14. Race - Americ Black, White, Specify:	
Baltimore, Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygene. is marked other than "natural", or Items 23a or 23a-f show aumatic event, the Medical Examiner must be notified at	Completed k	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+		(Give I life. D	ent's Usual Occup kind of work done PO NOT use retired	pation during m	nost of working			Kind of Business/In	
land 21	0 = 0 5	To Be Col	17. Father's Name (<i>First, Middle, Last</i>) Herbert Steinborn		HOM	emaker		ther's Name <i>(I</i>		Maider	wn Home	
, Mary	and 2 shou ealth and M n 27 is mar ner traumat		19a. Informant's Name/Relationship (Type. Print) Louis Schaffer	6	873	Mill Val	1ey	Dr., W	arrent	on,		
timore	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es		20a. Method of Disposition 1 🕅 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee		ngto	nition (Name of patory or other place	ry	May 3			ocation - City or To	
Ba	Derm Depa Impo any i		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	he death. Do	90	Name and Addre ans Fune Poplar or the mode of dyir	Ave.	, Carr			D 58421	Approximate
68760, /	Physician /Medical Examiner stree paragraphs	edical Examiner	Sequentially list conditions, if any leading leads or lead line. Due to (or as a Sequentially list conditions, if any leading Cause (Disease or injury that initiated events resulting in death) Last Sequentially list conditions, if any leading list conditions, if any leading to the last conditions of the leading list conditions in the last conditions of the last co	consequence RY TA consequence	e of): 2ACT e of):	INFEC						Approximate Interval Between Onset and Death Hours
P.O. Box 6	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as:	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal dea		Ectopic pregnancy Other (specify)	ý		-11-		23d. Date of delive Month	ery Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but	not resulting	in the un	derlying cause giv	en in Pai	rt I.		obacco Yes 2	,	he cause of death? bably 4 Unknown
Vital Records,		Completed	25. Was case referred to medical						1□ Yes	rmed?	prior to co death?	opsy findings available impletion of cause of 2☐ No
Division or Vit	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it	ation: To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatien 27. Manner of Death 1 Autural 5 Pending investigation 28a. Date of Injury (Month, Day)	28b	Outpatient Time of Injury	28c. Injur Wor	er: 4 🗆	28		dence	6 □Other (Special occurred)	fy)
DIVIS	oital or Atteurs after deseral Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of injurbuilding, etc.	(Specify)					City or Tov	vn, State		
	o the Hosp ithin 24 ho o the Fune ompletely f	Medical	29a. Certifier (Check only one) 1	examination a	ge, death and/or inv	estigation, in my o	ppinion, d	leath occurred	at the time,	date an	s) and manner as s ad place, and due to ate signed (Month,	o the cause(s)
)	F S F 8		30. Name and address of person who completed cause of dea	ath (Item 23a)) (Type, F	D6			1	APR	16 27 2	
	Sta	te	Amit Kalaria 9901 MED 31. Date filed (Month, Day, Year) 32. Registrar	ICAL (ER DRIV	Ε	Rockvi	LLE M	1)	20850	
	Registr	ar	MAY 0 0 2007 May			races.						

DHMH 17 Rev 1/2001

ORIGINAL

				For State Registrar		S	state o	f Mary		•	ent of l			Mental H	ygie Reg.	7.11		14305
		Physici /Medi		1. Decedent's Name Sandi	e (First, Midda Ca	le, Last)	Scru	bbs						2. Date of D Month May	eath	2007	Year	3. Time of Death 10:00% m
		Examir		4a. Facility Name (I. The Jos	not institution eph Ri	n, give stre Chey	et and nui Hospi	mber) ICE			City, Town, B alti l		n of Death			4c. County	of Death	
		Funeral Director		5. Social Security N 136–98–4	735	6. Sex 1 ☐ M	28ONF	7. Age (In 4'	yrs. last birti		nder 1 Year iths Days		er 24 Hrs. Min.	8. Date of B (Month 1) 2/28/1	1960	ar)	9. Birthi Cou	place (State or Foreign ntry) Tobago
		anyiand show	or .	Usuat Residence of 10a. State MD	10b. County	ward		100	c. City, Town		lumbi	a						10d. Inside City Limits
		with the M a or 28a-f Le notifi	Director	10e. Street and Nur 8857 F		tock	Row		***	10	f. Zip Code 2:	1045			10g.	Citizen of V		
	36	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or items 23a or 28a-f show ther then "naturel", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Marri 3 Widowed		ried	Was Deci Armed Fo 1 Tes If Yes, Gir Year or D	2 (Ž VNo ve	in U.S.		ecedent of specify Cut es 2 XNo			pecify Yes or No Rican, etc.)	10.		ck, White,	can Indian, etc. llack
	21215-0036	within 72 hours ene. then "naturel", ire M. dical Ext	Completed	(Spec	15. Deceder ify only highe odary (0-12)	st grade co	ion		16a.	(Give kind (life. DO N	Usual Occu of work done OT use retire	during mo d)	ost of worl	king	168	o. Kind of B	usiness/In	
		S in S	To Be Co	17. Father's Name Barnes		Last) idson						1	ther's Namertru	ne (First, Midda de Jol	le, Mai		ne)	
AM	Maryland	0 = 5 =	-	19a. Informant's Na BOD JO					19b. 2	Mailing Add	ress (Stree y Vale	t and Num	ber or Ru	ral Route Num de, Tok	ber, C	ity or Town,	State, Zip	o Code)
0	Baltimore,			20a. Method of Disp 1 ☐ Burial 2 4 ☐ Donation	Cremation		oval from	_	Ob. Place of cometed Rosehi	r. cremator	or other old	y N		Date , 2007	200	Linde		
Am	Balti	permit. Pages 1 Department of H Important: If ite eny injury or otl		21. Signatur	neral Service	Licensa	Mar	Shal	الم	²² Nam Cha 150	rles L Las	ess of Eac L St For	even:	s Funer enue, H	al alt	Home imore	Inc.	21230
-		Physician /Medical Examiner		23a. Part1. Enter the shock, or hea Immediate Cause disease or condition resulting in death)	rt lailure. List (Final	r complicati t only one o	ause on e	each line.	death. Do n	Sneas	mode of dy	ing, such a	as cardiac	or respiratory	arrest,	*		Approximate Interval Between Onset and Death
2/11/07	1760,	ite be executed ysicien and ne burial-transit	Ical Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	•	cd			nsequence o					=				
Solde	P.O. Box 68	ne death certific the attending pl hed for use as t	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 Ĵ	months? ☑No	23c.	1□Live t	nant at time	Fetal death		pic pregnanc or (specify) _	су ————————————————————————————————————					te of deliventh	ery Day Year
(2)		uires that the signed by Id be detac	þ	Part II. Other signif	icant conditi		outing to d		ot resulting in	-	ing cause g	ven in Par	rt I.		tobac	co use con		he cause of death?
Servens	l Records,	The law requi ate has been s page 2 should	Completed	Hyperca) cemi	a .								24a. Wa aut per 1 🗆 Yes	opsy formed	1?	Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of
)	f Vital	ysician: The la is certificate has director, page 2	To Be (25. Was case referexaminer?		Hos	pital:	Inpatient	2 ☐ ER/Out	patient 3(DOA O1	han		th <i>Check only</i>		e 6 VOth	ner (Speci	wHoloki.
100	ion of	nding Physath. ath. r: After this se funeral di		27. Manner of Deat 1 X Natural 2 ☐ Accident	5 Pendi	ng igation	28a. Date (Mon	of Injury oth, Day Yes	28b. T	me of jury M	28c. Inju Wo 1 [~ -		28d. Describe				
S	Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 □ Could determ		28e. Place buildi	ol Injury · ing, etc. (S	At home, far pecify)	m, street, fa	ctory, office			28f. Location City or T			er or Run	al Route Number,
()		To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one)	1 Certifyi 2 Medical	ng Physici Examiner	: On the b	e best of my easis of exa ener stated.	y knowledge mination and	death occi	irred at the t ation, in my	ime, date opinion, d	and place, eath occur	, and due to th rred at the time	e caus e, date	e(s) and mand place,	anner as s and due t	stated. o the cause(s)
	D	Tota	Σ	29b. Signature and	title of certifie	ar Lla		. 1/1			29c. Licen	se numbe	710		29d.	Date signe	d (Month,	Day, Year)
		7		30. Name and addr	ess of person	who comp	MSW pleted caus	7 MI se of death	(Item 23a) (Type, Print)	アウ		TIZ	£ 00	Fi	11/6) 	ANT.
		Sta	ate	31. Date filed (Mog	th. Day, Year	50 W.	32	legistrar's S	Signature	TEXPLO	0.30	N.Z	H'W	It. De	211	MI	3/2/	200
		Regist		31. Date filed (Mor	MAY 0	3 2007	/	Russ	S.	Spark	200							

		For State Registrar	State of Mary		artment of Heal		Hygien	CUU/	14307
Physicia /Medic		1. Decedent's Name (First, Middle, Last	V	SMIT			30	2007	3. Time of Death
Examine Funeral	er	4a. Facility Name (If not institution, give	MS HOSPI	yrs. last birthday)		Inder 24 Hrs. 8. Date (Mont	233	c. County of Death 9. Birth	place (State or Foreign
Director		Usual Residence of Decedent 10a. State 10b. County		Yrs. Oc. City, Town or Lo		9)	14/1	1942	10d. Inside City Limits
Marylan f show	5	MD		BALTIM					1 X Yes 2 No
ith the M or 28e-f	Director	10e. Street and Number			10f. Zip Code		10g. C	itizen of What Cou	ntry?
death with the Maryland ms 23a or 28e-f show Imust be notified at	<u>a</u>	2136 ASHBURTON ST	REET		21216			USA	
urs after	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispani If Yes, specify Cuban, Me 1 ☐ Yes 2 ★No Specify	ic Origin? (Specify Yes exican, Puerto Rican, etc	or No-	14. Race - Ameri Black, White, Specify: BLA	etc.
72 hours naturel;	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usual Occupation kind of work done during	most of working	16b. l	Kind of Business/Ir	ndustry
ithin 78	Completed	Elementary/Secondary (0-12)	Coltege (1-4or 5+)	life.	DO NOT use retired)	, most or norming			
filled v Hygie other ti		17. Father's Name (First, Middle, Last)		HO	MEMAKER	Mother's Name (First, M		HOME	
	To Be	JAMES KENNARD			10.1	ARVELL F		,	
ice, Marylan than 2 should be thealth and Mental item 27 is marked other traumatic ev	-	19a. Informant's Name/Relationship (7) HARRY W. SMITH/HU			ng Address (Street and N		-		D Code)
of He of He		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F		20b. Place of Dispo cemetery, crea	sition (Name of matory or other place)	Date	20c. L	_ocation - City or T	own, State
DSBILLIMOR permit. Pages Department of importent: If its Importent: or o		4 Donation 5 Other (Specify)		INION CHA	PEL CEMETERY	Y 05/05/07	CAN	BRIDGE,	MD
Dalt permit. Departi Import		21. Signature of Funeral Service Licens	1 to	22	Name and Address of F	DRTON & SON	S F.H.	, INC	
Cate be executed by Stricture of the burial-transit cate by Stricture of the burial-transit cate by Stricture of the burial-transit categories.	al Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of): NOVA onsequence of): HER	er the mode of dying, suc	NS ST., BAL	ory arrest,		Approximate Interval Between Onset and Death
Certificate be right of properties of properties of physicial use as the burning of properties of the pure propert	edical		1						
GOrds, P.O. BOX of wrequires that the death certific been signed by the attending p should be detached for use as it.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
The law requires that the death The law requires that the death ate has been signed by the atter page 2 should be detached for u	۵	Part II. Other significant conditions co	ENAL DISE	EASE ON	HEMODIAL		Did tobacco		he cause of death? bably 4 DÜnknown
VICAL MECOFICS, idean: The law requires t certificate hes been signerector, page 2 should be to	Completed	HUPERTENS	ilon;	DIAMET	es mell		Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
rtifical	0	25. Was case referred to medical			26.	Place of Death (Check of		o 1 ☐ Yes	2□ No
nysici nis cer direc	10 B	examiner? 1 ☐ Yes 2 S No	lospital:	2 ER/Outpatier	Other	□ Nursing Home 5□		6 □Other (Special	fy)
	Certification:	27. Manner of Death 1 \(\sum \) Natural 5 \(\sum \) Pending 2 \(\sum \) Accident investigation 3 \(\sum \) Suicide 6 \(\sum \) Could not be	28a. Date of Injury (Month, Day Ye	ear) 28b. Time o	28c. Injury at Work? M 1 \(\t \) Yes		ribe how inju	ury occurred	
ital or Att		4 Homicide determined	28e. Place of Injury - building, etc. (S	Specify)		City	r Town, Stat		
ths Hosp in 24 hou the Fune	edicai	29a. Certifier 1 ⚠ Certifying Phy (Check only one) 2 ☐ Medical Exami	sician: To the best of m ner: On the basis of exa and manner stated.	amination and/or in	n occurred at the time, da vestigation, in my opinion	ite and place, and due to i, death occurred at the	the cause(s	s) and manner as s nd place, and due t	stated. o the cause(s)
To To To Com	Σ	29b. Signature and title of certifier	moph bel	i mo	29c. License num			ate signed (Month,	
10		30. Name and address of person who co	ser mo	מבמצ	Print) GAVIIM	DE ST., 6	BALTIN	none, m	0 21273
Stat Registra	ar	31. Date filed (Month, Day, Year) MAY 0 3 20	32 Pegistrar's	Signature	who .				
DHMH 17 Rev 1/20	01		4	-					•

		F	Please T				ndelible Ink					_	e.	
	1	For State Registrar		State of Ma	arylan	-	partment of F ertificate of		and M		gien Reg. No	000	7	11.200
Physicia		1. Decedent's Name (First,		C = 0 \ \						2. Date of De		Ca 11 10	- der	3. Time of Death
/Medica	l er	TUANITI Aa. Facility Name (If not ins		STOK	6 >		4b. City, Town, o	y Location o		APRIL	30	c. County of	001	9:19 A M
Examine	r	NORTHWEST		SPITAL	CE	NTER		PALLS	S TO	No		BAL-		NORE
Funeral Director		5. Social Security Number 224–34–6451	6. Sex		e (In yrs. I 77	as <i>t birthd</i> a Yrs.	y) If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir 09/10/3/00/20		9	Birthp Coun	
2	-	Usual Residence of Decede			10. 01	-								NC
Marylar f show ied at	5	10a. State 10b. C	county		·	, Town or LTIMO							1	0d. Inside City Limits 1 XYes 2 No
ith the	Jirec	10e. Street and Number			L		10f. Zip Code				10g. C	itizen of Wha		try?
II C I C I D-UU30 filed within 72 hours after death with the Maryland Hygiene ther than "natural", or Items 23a or 28a-f show ont, the Medical Examiner must be notified at	Funeral Director	1638 RUXTON		E 12. Was Decedent I	Ever in II	S 19	21216	disnanic Orio	gin? (Sne	cify Ves or No	D- 1	USA 14. Race -		an Indian.
after d or Item miner		1 Never Married 2	Married	Armed Forces? 1 Yes 2 1		J. 10	 Was Decedent of H If Yes, specify Cub 1 Yes 2 Xo 		n, Puerto I	Rican, etc.)		Black,	White,	
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Dealt Departi Importi any Inj		21. Signature of Euneral S	ervice License	*. Ma	7		22. Name and Addre	ess of Facility	1 2	OI La		^	-	116. MP H - 21217
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death cer attendin	cian	23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 🕱 No	arii	3c. If yes, outcome 1□Live birth 4□Pregnant at	2 Feta	death 3	B ☐ Ectopic pregnanc	;y				23d. Date of Month		ery Day Year
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		(Check only 2 Mi	ertifylng Phys edical Exami	ner : On the basis o	f examina	wledge, de tion and/or	eath occurred at the ti	ime, date an opinion, dea	nd place, a	and due to the ed at the time	e cause(s) and mann	er as s	tated. the cause(s)
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13		30. Name and address of p	person who co	impleted cause of d	eath (Item	23a) (Typ	e, Print) NOR	WAIT	T23	off PNOC	SPI	TAL	2	ENTER BOULS
State	е	31. Date filed (Month, Day,		32. Polistr	ar's Signa	ture	<u> </u>	1 0	Cyc	200111	. 10	VIIV	11	V 011931
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** :150 lavleme 8 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Nursing lare breen If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Min 1 ☐ M 2 💢 F Yrs. 213-30-1056 Director Jan Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a State ir then "natural", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director Md timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21212 rose 115 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [MNo If Yes, Give 7 Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Jack 13 3 5 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) i. Pages 1 and 2 should be filed withent of Health and Mental Hygiertant: If Item 27 is marked other thury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be len ပ toste 1 19a. Informant's Name/Relationship (Type, Pri 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter Maureen 4620 Parksid 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or once. Mem -2007 rurk 29. Name and Address of Facility of a 1701 Mc Cull oh S 21. Signature of Funeral Service Licensee is Funeral Service 51. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ement.c /Medical Due to (or as a consequence of) Examiner tailwe Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed attending physicien and for use as the burial-translt PLESTAS IN resulting in death) Last Due to (or as a consequence of): Medical Certification; To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has funeral director, page 2 1 Yes 2 1 No 1 Tyes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Tes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 PNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manny r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of centifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of pe

31. Date filed (Month, Day, Year)

2007

Division of Vital Records, P.O. Box 68760,

ORIGINAL

who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

0664788

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 0:50P.M **Physician** 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Howard Harmony Hall Columbia If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Yrs. 578-01-5293 91 May 31, 1915 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show init. Pages 1 and 2 should be filed within 72 hours after death with the Maryla affirment of Health and Mental Hygiens, ordent: If them 21s marked other than "naturel; or thems 23s or 28s-1 show injury or other traumatic event, the Medical Exemism must be usuffilled at injury or other traumatic event, the Medical Exemism must be usuffilled at 1 Yes 2 No Director MD Howard Columbia 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21044 USA 6336 Cedar Lane #374 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Baltimore, Maryland 21215-0036 Specify: Specify: þ White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Police U.S. Treasury 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Augusta Krause George Beverly Sunderland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 409 Carlisle Blvd. NE Albuquerque, NM 87106 Virginia Sunderland/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 05/03/07 Beltsville, MD Chesapeake Crematory 1 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service P.O. Box 784 Clarksville Mi Approximate Interval Between Onset and Death permit.
Departminitude importerany inju 21. Signature of Funeral Service Licensee P.A. MO1251 Beverly L. Heckrotte, 23a. Part1. Enter the essease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signe should be þ 1 Tes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 **2** No certificate 1 ☐ Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 KNo ဠ 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20+1 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 03 2007

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DHMH 17 Rev 1/2001

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Physician / Medical Examiner Physic	, e	s 1 a of Hei Item othe			7	comet	of Disposition (Natery, crematory or	ame of other place)		- 1	20c. Location	- City or To	wn, State	
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Physician / Medical Examiner Physic	alti d	rmit. partn porta y Inju		21. Signature of Funeral Service Lice	nsee M		22. Name a	and Address	of Facility					
Sequentially list conditions resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that imitated events resulting in death) Last Pure of the condition of the conditions of the c	<u>n</u>	8 3 E 6 8			Mitter		8717	Green	Pastures	Drive	Baltimo		ryland 2	1286
Physician /Medical Examiner Page Physician / Medical Examiner Physician / Physic	1			23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that caused one cause on each li	d the death. Do		-			•		Interval Between	n
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24a. Was an autopsy performed to completion of cause death? 25. Was case referred to medical examiner? 1	S,	ss tha gned se dei		A)	contributing to death t	out not resulting	in the underlying	cause given	ı in Part I.			4.5		
24a. Was an autopsy performed death? 25. Was case referred to medical examiner? 1	p	en sle		/Vone_			_ -			1 🗆	Yes 2∐ No	3 Prob	abły 4 ∐Unkr	nown
Composition Composition	~~	law ras be	ple							autor	psy	prior to co	psy findings avai mpletion of cause	ilable e of
25. Was case referred to medical examiner? 174 Ve 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 28 Place of Death (Check only one) 28 Place of Death (Check only one) 28 Place of Death (Check only one) 28 Place of Death (Check only one) 28 Place of Death (Check only one) 28 Place of Death (Check only one) 28 Dother: 4 Nursing Home 5 Residence 6 Other (Specify) 28 Describe how injury occurred 29 Describe how injury occurred 29 Describe how injury occurred 29 Describe how injury occurred 29 Describe how injury occurred 29 Describe how inj	CE	he are h	E O									death? 1 ☐ Yes	2 No	
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		To th within To th	Me	29b. Signature and title of certifier	11		2	29c. License	number		29d. Date sign	ned (Month,	Day, Year)	
Demand & Yulkia MI) DME SYDD/4206 May 1. 2007				Bernarda	War MI	DME		1800/	4206		Maur	,200	2	
30. Name and address of the sort in completed cause of death (Item 23a) (Type, Print)		(X)		30. Name and address of reson the	completed cause of	death (Item 23a	a) (Type, Print)	11. 1.10.	(4) 11. A	1 > -	1	i -		
30. Name and address of the sort ho completed cause of death (Item 23a) (Type, Print) BERNARD T. YUKNA MD. DME 1614 (HURCHVILLE Rd BEL AIR, NId 21015	_	ン		BERNARD J. Y	UKNA MI	DME	1614 (1	HYKCH	VIIIE Rd	BELA	IX, XId	210	15	
State 31. Date filed (Month, Day, Year) 33. Registrar's Signature Registrar MAY 0 3 2007					32 Regist	trar's Signature	Angell .							

		-	For State of Mai		rtment of Health and N <i>tificate of Death</i>		ene g. No.)	11.312
a			1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
h	Physicia /Medic	al	Catherine Lillian Schrott			May 1,		11:00P ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	1
			403 W. Ordnance Road, #419	(la la at biutt da)	Glen Burnie If Under 1 Year If Under 24 Hrs.	8, Date of Birth	Anne A	rundel pplace (State or Foreign
	Funeral		1□M 2X0F	(In yrs. last birthday) Q Yrs.	Months Days Hours Min.	(Month, Day, 01/02/1	Year) Cou	intry) PA
	Director	-	192-28-3496 8			01/02/1	919	IA
	ow at	ŀ	10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	Mary Fish	호	MD Anne Arundel	Glen Burn	ie			1 □Yes 2 No
	r 28a	ie	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Co	untry?
	h wit	Funeral Director	403 W. Ordnance Road, #419		21061		U.S.A.	
	deat	ner	11. Marital Status 12. Was Decedent Every Armed Forces?	/er in U.S. 13. \	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No. If Yes, Give 3 🖫 Widowed 4 ☐ Divorced Year or Dates:)	I∐Yes 2⊠No <i>Specify:</i>		Specify:	white
Õ	72 ho natur lical B	Completed	15. Decedent's Education (Specify only highest grade completed)	1 (Give	lent's Usual Occupation kind of work done during most of work		6b. Kind of Business/I	ndustry
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pu	be fill tal H d ott	Be	17. Father's Name (First, Middle, Last)			, ,	,	
yla	ould Mer narke	٩	Edward P. O'Connor	10h Mailir	Catheri G Address (Street and Number or Ru	ne Borge		in Code)
Maryland	12 sh h and 7 is n traun	l- II	19a. Informant's Name/Relationship (Type. Print) Mr. Robert C. Schrott III /		8 Chelton Lane; E			ap code)
e, 1	1 and Healt em 2	1	20a. Method of Disposition		sition (Name of natory or other place)		20713	Town, State
nor	ages int of t: if it / or o		1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 4 ☐ Other (Specify)	1	te Cremation 05/0	5/2007	Stavancyil	lo MD
Baltimore,	nit. Partme		21. Signature of him at Service Licensee		2. Name and Address of Facility Si			
B	Dep Imp any onc	0 0	Lusoh mo	1364 1	Second Ave SW; G	len Burn	ie, MD 210	
			23a. Part1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line	he death. Do not ent	er the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between
V.	Physician	2 1	Immediate Cause (Final	nonare	hbrosis			Onset and Death
	/Medical		roculting in death)	consequence of):				
6	Examiner		Sequentially list conditions, b.					
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Box	leath certifi attending I for use as	N/	IF FEMALE: 23b. Was decedent pregnant		∃Ectopic pregnancy		23d. Date of del	,
	death e atte	Physician/M	in the past 12 months? 1 Ves 2 No 9 Unknown		Other (specify)		Month	Day Year
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	The law requires that the death certifice has been signed by the attending tage 2 should be detached for use as	by F	Part II. Other significant conditions contributing to death bu	t not resulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute to es 2 Mo 3 □ Pr	robably 4 Unknown
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Div	after after i Dire d in b	Certification:	4 Homicide determined building, etc	. (Specity)		City or Town	, State)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner sta	examination and/or in	th occurred at the time, date and place evestigation, in my opinion, death occurred	e, and due to the caurred at the time, do	ause(s) and manner as ate and place, and due	s stated. e to the cause(s)
	o the	Me	29b. Signature and title of certifier		29c. License number	25	9d. Date signed (Mont	h, Day, Year)
	⊢ ≶ ⊢ ô		Mol 5 Valento	MI	1) 00 3789	6	5/21	07
	5		30. Name and address of person who completed cause of de	eath (Item 23a) (Type,	Print)		7 13	
	٧)		Ners E Padgeto 7	711 Que	itsheld RD 6	en Burn.	e m)	
	St	ate	31. Date filed (Month, Day, Year) 32 Registra	r's Signature	Print) Co 37 Eg			
	Regist	rar	MAY 0 3 2007 LONG	A STA	Section of the sectio			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per inf 9869 7-20-07 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:40P ^M APRIL 29 2007 SCHERR **FLORENCE** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE BRIGHTON GARDENS OF PIKESVILLE PIKESVILLE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗶 F ΜĎ 90 06/10/1916 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 1 ☐ Yes 2 No PIKESVILLE **Funeral Director** MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21208 USA 1840 REISTERSTOWN ROAD 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Specify Completed by 3 XWidowed 4 □ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HAMBURGER MOLLIE APPLEFELD **JACOB** မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 6101 MAYWOOD AVE. BALTIMORE, 21209 MD JEFFREY H. SCHERR / SON 20b. Place of Disposition (Name of ARLINGTON CEMETERY CHIZUK AMUNO 20c. Location - City or Town, State Date 20a. Method of Disposition Department of H
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/01/2007 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final week Due to (or as a consequence o) disease disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of): IE FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by dubetes nellas 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No hapentensien 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Physician /Medicai Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, been signed by the should be detached has e 2 page certificate or Attending Physician: director, After this after death.

within 24 hours after death

To the Funeral Director:
completely filled in by the

Director

show

ral", or items 23a or 28a-f shov Examiner πust be notified at

"natural"

other traumatic event, the Medical

and Mental Hygiene.

item 27 l

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

29c. License number

School o Bay . 4D

020604

29d. Date signed (Month, Day, Year)

#450; 10755 Fells Rd, Lothunlle, 4d 21093

4 PRIL 30 07

Richard A. Berg. 4D 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

MAY 0 3 2007



Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 2007 6:15a.™ Altimont Terrelonge May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Catonsville Summitt Park Nursing Home If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 XM 2 ☐ F 215-27-7158 Usual Residence of Decedent 60 02 04 Jamaica **Director** 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Show r 28a-f show notified at 1X Yes 2 □ No Director NA Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or edical Examiner must be U.S.A. 14. Race - American Indian, Black, White, etc. 21215 Funeral 2528 Edgecomb Cir North 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 7 is marked other than "natu traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chief Pimlico Race Track 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adolphus Terrelonge <u>Adela Baines</u> 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1715 Chaplain Drive, Baltimore, Md Cordia Tamika Terrelonge 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of H important: If ite any injury or of 1 Burial 2 Cremation 3 Removal from State King Memorial Park 5/12/07 Randallstown, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IV Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 5 □ Other (specify) ___ Month Year in the past 12 months? Day ed by the a detached f 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Udnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes Be 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 055258 30. Name and address of ers Tiwho completed cause of death (Item 23a) (Type, Print) big Road, Columbia m) 21046

State Registrar ed (Month, Day,

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2007

DHMH 17 Rev 1/2001

32. Registrar's Signature

07-03303 Patricia Tharringt	ton-		oe or Print in ate of Maryla								egib		10	···
		1- For State Registrar	_		tificate of						Reg. N			7 [43]
Physicia Medical Examir	n/	Decedent's Name (First, Midd Patricia	le,Last)	Th	arring	ton-	-Bat	tes	1	2. Date of D Month April 30	Da	y Year		3. Time of Death 1800 hrs
		4a. Facility Name (if not instituted Northwest Hospital Co	_			b. City, To Randa	own, or L	Location	of Death	-1/-		4c. County o Baltimore		nty
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. Ia	ast birthday)	If Under		_	er 24Hrs.	1	Birth(N		9. Birth Foreign	nplace (State or
Director		215-88-1080 Usual Residence of Decedent	1 M 2X F	43	Yrs.	Wichard	Days	, nour		07	28	63	Cou	ntry) MD
d d fow any		10a. State 10b. County	imore	10c. City,	Town or Locati		i 1 1 s	s				•		10d. Inside City Limits 1 Yes 2 No
Maryland Maryland r 28a-f sho	Director	10e. Street and Number	THOLE		0 11 2119	10f. Zip (10g. (Citizen of Wh	at Coun	try?
3a or 3	اق	l Tri Count						117				U.S		
death with r items 2	Funeral	11, Marital Status 1 Never Married 2 N	12. Was De Armed F 1 Yes	cedent Ever in U. orces? 2 X No						ecify Yes or Rican, etc.)	No-	14. Race White		an Indian, Black,
after a	by F		vorced If Yes, Give Ye	ar	1 16a. Deceden	Yes 2				ork dono	116	Specify: b. Kind of But		lack
Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12th grade	College (1-4 or 5+)		ost of work	ing life.	DO NO				Wal-		
d with ygiene ygiene other the	Com	17. Father's Name (First, Middle		715	110000				er's Name	(First, Middl	e, Maio	den Surname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Media	Be	Robert Thar			40h Mailine	. Add				Smith	_	City or Town	- Ctata	Zin Cada)
ID 2: should and M 7 is m: natic e	ို	19a. Informant's Name/Relation Devon Bates-					•					r, City or Town imore		
Baltimore, MD permit Pages I and 2 ahd Department of Health and Important: If item 27 is injury or other traumati		20a. Method of Disposition 1 X Burial 2 Crematio		from State K 1	Place of Dispos	ition (Nam	e of cen	netery,		Date	20	Oc. Location -	City or	Town, State
Pages ment of tant:		4 Donation 5 Other S	Specify:	-	Woodla	wn		-00-0	5/7	/07	В	altim	ore	Co, Md
Balt permit Depart Impor injury		21 Signature of Foneral Service	e Licensee		²² / _M 6	lame and A	Address	H W	est Ave	. Ba	l + i	more,	Mđ	21215
Physician		23a. Part I. Epter the disease, of failure. List only one cause	r complication that	caused the death	. Do not enter the	ne mode o	f dying,	such as	cardiac or	respiratory	arrest,	shock, or hea	art	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final diseas or condition resulting in death)	e a. <u>Acute c</u>	coronary ar		sectio	n							Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Coult	F21 1000	a consequence o	of):									
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be exect be iscian an urial - tr	dical	X UNPENDED	X AMENDED #23a,	#19a,20 27,perME,9	b,perFH,0 2867,5/10	867,5 707 1 11	/18/0	07,WS						
Division of Vital Records, P.O. Box 68760, lospital or Attending Physician: The law requires that the death certificate be executed burstand affected. Internal Director, After this certificate has been signed by the attending physician and ly filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 1 Live	, outcome of preg birth gnant at time of de	2 Fe	tal death	3 (Ectop	oic pregna	ncy		23d. Date of Month		Day Year
Box e death the atte	hysic			nown		2022			and a				15	1)
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/ital sician: is certi	o Be	25. Was case referred to medic examiner? 1 ✓ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatient			Other;		g Home 5	Re	sidence 6	Other	:
of V ing Phy After th	-	27. Manner of Death		te of Injury hth, Day,Year)	28b. Time of	njury 2		iry at Wo	_	28d. Descr	ibe hov	v injury occur	ed	
Division of ¹ ospital or Attending Phonus after death. nueral Director: After ty filled in by the funeral	Certification:	2 Accident Inv	estigation 28e. Pla	ace of Injury - At h	nome, farm, stre	et, factory,		Yes 2 ouilding,		28f. Locatio	on (Stre	eet and Numb	er or Ru	ral Route Number, City
Divi	ertif	4 Homicide	uld not be ermined (Specif							or Tow	n, Stat	e)		
, E 2 E S		29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the b	est of my knowled	ige, death occu	rred at the	time, da	ate and i	place, and	due to the	cause(s	s) and manner d place, and o	r as stat	ed. e cause(s)
To the complete	Medical	29b. Signature and title of certification	and manner	stated.				se numb						nth, Day,Year)
		Caro	e Ha	lla	~		O.C.	M.E.				May 1, 200)7	
d		30. Name and address of person Carol Allan, MD A	on who completed ca		^{n 23a)} 111 Penn	Street, I	Baltim	ore, M	ID 2120	1				
	tate	31. Date filed (Month, Day Year		Registrar's Signat				<u>-</u>						
Regis	uiel	HIMI V U	W. 17 W.		-									

			riease	State of Manuand				-	•	
		•	For State Registrar	State of Maryland		artment of Heal			g. No. 007	14317
	Physici		1. Decedent's Name (First, Middle, Last					2. Date of Death Month		3. Time of Death
	Physicia /Medic	al		Trail Jr.				May 2	2007	12:25a [™]
	Examin	er	4a. Facility Name (If not institution, give 11639 Copper Min			4b. City, Town, or Local Union Bri			4c. County of Deal	
- 1	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. las	st birthday)	If Under 1 Year If U	-	8. Date of Birth (Month, Day,		hplace (State or Foreign
jār.	Director		213-44-6943 X	M 2□F 60	Yrs.	Months Days Ho		Dec 3		hington DC
	Maryland -f ehow ied at	tor	10e. State 10b. County MD Frederic		Town or Lo	Bridge				10d. Inside City Limits 1 ☐ Yes 2 No
	filed within 72 hours after death with the Maryland Hygiene. ther than natural; or items 23s or 28s-f show ent, the Madical Examiner must be notified at	il Director	10e. Street and Number 11639 Copper Mine	Road		10f. Zip Code 21791			g. Citizen of What Co	buntry?
	death	nera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of Hispan If Yes, specify Cuban, Me	nic Origin? (Sper	cify Yes or No-	14. Race - Ame Black, Whit	
920	ours after rai', or ite Exemine	by Funeral	1 Never Married 2 Marned 3 Widowed 4 Divorced	1 ☐ Yes 2√ No If Yes, Give A Year or Dates:	1		ecify:	ncari, etc.)		hite
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72	withir iene. than	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		ng/air cont	ractor	ŀ	neating &	air
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Meniat Hypiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any rightry or other traumatic event, the Madical Examinar must be notified at ance.	To Be C	17. Father's Name (First, Middle, Last) James Riley Trai			18.	Mother's Name	(First, Middle, M	laiden Sumame)	
Mary	nd 2 shou lith and N 27 is mai		19a. Informant's Name/Relationship (T) Jan Trail (spouse)			ng Address (Street and N Copper Min				
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Ē	tment tment tant:		4 Donation 5 Other (Specify)	ALL		y Cremation			Sykesville	
Ba	Departing Important in processing in process		21. Signature of Funeral Service Licens Paige Harige	topenent	P	2. Name and Address of .O. Box 195	Sykesv	ille, MI	21784	& Chapel
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ilications that caused the death. ne cause on each line. a	U L	er the mode of dying, su	ich as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death
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Vita	entifica ctor, p	BeC	25. Was case referred to medical examiner?			26.	Place of Death	(Check only one		2EZNo
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ou	ding f h. After funer	tlon	27. Manner of Death 1 □ Matural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time o Injury	f 28c. Injury at Work? M 1 Yes	1	28d. Describe ho	w injury occurred	
Division of	i Diffic	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, st			28f. Location (Str City or Town	eet and Number or Ri , State)	ural Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dirr completely filled in I	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	rsician: To the best of my know iner: On the basis of examinatio and manner stated.	edge, deat on and/or in	h occurred at the time, do	ate and place, a n, death occurre	and due to the ca	use(s) and manner as ite and place, and due	s stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	-		29c. License nur	mber	29	d. Date signed (Mont	h. Day, Year)
•	17		* Cornert & P	Lee MD, PhD		Dood	(459	7	5/2/1	7
	10		30. Name and address of person who c	ompleted cause of death (Item 2	23a) (Type,	Print) Rober	FL. RI	cz, M.D		
	Sta	te	31. Date filed (Month, Day, Year)	nter Street, B2. Registrar's Signatu	re 2	minsy Ir	11/7/11	1 +		
	Registi		MAY 0 3 2007	Beech &	ADDA	E				

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State of Manyland / Department of Health and Mental Hygiene

nothy Utterback	1- For State Of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department / Department /		No. 2 (1 1 1 1 1 2 2
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death Month D	3. Time of Death
edical Examine		April 29, 200	4c. County of Death
×.	4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center	Glen Burnie	Anne Arundel
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8. Date of Birth (Months Days Hours Min. 06/01/	Foreign
Director	Usual Residence of Decedent		10d. Inside City Limits
d d	10a. State 10b. County 10c. City, Town or Loc	Pasadena	1 Yes 2 X No
the Maryland a or 28a-f show tifted at once.	10e. Street and Number 8012 Mansion House Crossing	10f. Zip Code 21122	, Citizen of What Country? USA
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland the and Mental Hygient. n 27 is marked other than "natural", or items 23a or 28a-f she numric event, the Medical Examiner must be notified at once the December of the Enterprise of the	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No	Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 X No specify:	14. Race - American Indian, Black, White, etc. Specify: White
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5-0036 ed within 72 hour lygiene. other than "natu	12 4	Carpenter 18. Mother's Name (First, Middle, Mi	Construction
1D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than matic event, the Medical	Raymond Utterback	Beverly H	i CKOX
MD 21 ad 2 should dith and Me n 27 is ma aumatic ev	Tammy Sue Utterback (spouse) 80	12 Mansion House Crossing	, Pasadena, MD 21122
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and I Important: If item 27 is in injury or other transition.	1 XBurial 2 Cremation 3 Removal from State Hillsb0	rotherplace) May 04 ro Cemetery 2007	Hillsboro, Virginia
Baltir permit. P Departm Importa injury on	21. Signature of Funeral Service Licensee	3111 Mountain Road, Pasa	s Funeral Home, P.A. dena, MD 21122
Physician '_edical	23a. Part I. Enter the disease or complications that eaused the death. Do not entrailure. List only one cause on each line. Immediate Cause (Final disease a. Complications of chronical contents of		Between Onset and Death
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30, te be exec sysician an	X UNPENDED X AMENDED #1.23a.PIT.27.perMF. IF FEMALE: 23c. If yes, outcome of pregnancy	g867, 5/22/07 TT	23d. Date of delivery
Division of Vital Records, P.O. Box 68760, the Ilospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. The law requires that the death certificate has been signed by the attending physician and the Funeral Director: After this certificate has been signed by the attending physician and inpetely filled in by the funeral director, page 2 should be detached for use as the burial a transit	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregnancy Other (Specify)	Month Day Year
. Boy	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the significant conditions.	the underlying occurs given in a man	obacco use contribute to the cause of death?
P.O es that the general properties of detaction	Cocaine use	1 Yes	s 2 ✓ No 3 Probably 4 Unknown
Division of Vital Records, P.O. ral or Attending Physician: The law requires that thers after death. "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacl	O D D D D D D D D D D D D D D D D D D D	24a. Was autor perfo 1 ✔ Yes	prior to completion of cause of death?
Rec The lifeate	COU	26.Place of Death (Check only one)	2 10 10 103
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n of Viling Phys After thi		e of Injury 28c. Injury at Work? 28d. Describe	how injury occurred
ivisior I or Attend after death Director: d in by the	2 Accident Investigation 28e. Place of Injury - At home, farm,	, street, factory, office building, etc. 28f. Location (or Town, \$	Street and Number or Rural Route Number, City State)
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phonon property filled in by the funeral director, page 2 should be detached for use as the	1 X Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death one) 29b. Signature and fittle of certifier 29b. Signature and fittle of	occurred at the time, date and place, and due to the cau	se(s) and manner as stated.
To the comple	one) Medical Examiner: On the basis of examination and/or live and manner stated 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	- Way	O.C.M.E.	April 30, 2007
<i>\delta</i> ;	30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistan Medical Examiner 111	Penn Street, Baltimore, MD 21201	
St	ate 31. Date filed (Martin Day Year) 2007 32 Registrar's Signature	hadis	
Regist		5 400 F. C. J. C.	

DHMH 17 Rev 1/2001

State

Registrar

LIEN NGUYEN, THE JOHNS

MAY 0 3 2007

31. Date filed (Month, Day, Year)

3. Registrar's Signature

			For State Registrar	State of	Marylar		epartment of Certificate of				601	The same of the sa	14320
			Registrar Decedent's Name (First, Middle, La.	st)			ertinicate or	Deal		2. Date of Dea	ith		3. Time of Death
1000	Physicia		Raymond J. White		r.					April	20 2	507	12:32 AM
7	/Medic Examin		4a. Facility Name (If not institution, giv				4b. City, Town,	or Location	on of Death	11/1/20	4c. County		
			Belair Healt	nandl	kena	Ŋ	Be	lai	r		Har	+01	d
	Funeral		Social Security Number 6. S	ex 7. 12∏ M 2 ☐ F	. Age (In yrs.	last birtho	Months Davs		der 24 Hrs. rs Min.	8. Date of Birth (Month, Day	, Year)	Cour	
	Director		216-36-6997 Usual Residence of Decedent	A _	67		s.		(Oct. 10	, 1939 1	1ary	land
	saryland ehow		10a. State 10b. County		10c. Ci	ty, Town o	r Location					1	10d. Inside City Limits
	a-f et	ctor	Maryland Harford		Ed	gewoo	d						1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of W	hat Cour	ntry?
	ier death with the Maryla Items 23e or 28e-f ehov Item must be motified at	rai	1864 John Drive	L 40 111 - D			21040		01.015		.S.A.		
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O. 1	the e	ysic	1 Yes 2 No	4□Pregnar 9□Unknow	ntattimerofo vn	leath	5 Other (specify)				INION		Day
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[0]	Physician: r this certifice ral director, i	٩	1 ☐ Yes 3 No	Hospital: 1 🗆 Ing		ER/Outpa	tient 3LI DOA		Nursing Hom	e 5 Resid	ence 6 □Othe	r (Specif	(4
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	To the Hospital or A within 24 hours after of to the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) Certifying Ph	niner: On the bas	is of examina	owledge, d	eath occurred at the to investigation, in my	ime, date	and place, and death occurre	nd due to the c d at the time, d	ause(s) and mar late and place, a	ner as s	lated. o the cause(s)
-	To the Hos within 24 hr To the Fur completely	Med	29b. Signature and title of certifier	and manne	er stated.		29c. Licen	se numbe	er	2	9d. Date signed	(Month,	Day, Year)
	F 5 F ŏ		AII	112			DZ	V/ 1	T2			20	27
	la		30. Name and address of person who	completed cause	of death (Iter		pe, Print)	10)		7,1	1	2,000
	Sta	te	31. Date filed (Month, Day, Year)	// d 32. Reg	Nov J gistrar's Signa	4 A	4/4 H /	131	/ A1.	- MG	14/440		d1017
	Registr		31. Date filed (Month, Day, Year) MAY 0 3 200	1 plan	w St.	Spe	er les						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Jeannette Clara Gibson West 2007 6:02pm Mav 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carrol1 Carroll Hospital Center Westminster If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2 💢 F 219-26-7885 69 MD Feb 6 1938 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Carrol1 Sykesville 1 XYes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7612 Schoolhouse Road 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard B. Vernon Clara Pinkney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Joseph West (spouse) 7612 Schoolhouse Rd., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) White Rock UMC Cem. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 5-5-07 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHaight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Day Haight Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 48 Hairs disease or condition resulting in death) Due to (or as a consequence of) 48/tours MYOCARDIAC INFARCTION Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse uence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2☐ No autopsy 1∐ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 1 Natural

Examiner transit certificate be executed and burial-t Division or Vital Records, P.O. Box 68760, attending physician for use as the buris signed by the a been has Physician: To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, Certification:

Physician

/Medical

Examiner

MD

Director

Funeral

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Completed

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Funeral

Director

item 27 is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

within 72 hours after

Pages 1 and 2 should be 1 nent of Health and Mental I surt; if item 27 is marked or

permit. Pages 1
Department of H
Important: If ite
any Injury or ot

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Physician/Medical þ Completed Be P

IF FEMALE: 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

and manner stated

25. Was case referred to medical examiner? 1 Tes 27. Manner of Death

> 2 Accident 3 ☐ Suicide

4 Homicide

29a, Certifier

28a. Date of Injury (Month, Day Year) 5 Pending investigation

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

29c. License number DO059552 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

POOLE RO WESTMINSTER NAGANA 700 A 6-04RISHANAM 31. Date filed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

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Medical

MAY 0 3 2007

6 ☐ Could not be



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deathy 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 25 :29 /M 200 David M. Warfel 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Itimore Se 05 (0) -da Salvare If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 8-24-1937 7. Age (In vrs. last birthday) 6/ Sex 9. Birthplace (State or Foreign Social Security Number Days Hours Min. 1 M 2 □ F PA 170-28-8006 69 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes ¾□ No MD Baltimore Dundalk 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1724 Drexel Road 21222 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 G Yes 2 No If Yes, Give Year or Dates: 1 9 5 6 − 5 9 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Defense 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Lee Warfel Edith Mae Courtney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1724 Drexel Road, Dundalk, MD 21222 Patricia D. Warfel - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Bayview Crematory 4-30-07 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service License It 2134 Willow Spring Road, 21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final er disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequent e of): betes a resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 2 🗆 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

certificate be executed

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Records,

Division or Vital

Physician

/Medical

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Funeral

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item 27 is marked other than "natural", or items 23a or other traumatic event, the M-dical Examiner must be in

filed within 72 hours after Hygiene.

12 should be filed within 7 in and Mental Hygiene.
7 is marked other than "r

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Examine burial-transi and attending physician for use as the buria Physician/Medical e detached f s been signed by the should be detached

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Certification: To

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page 2 s has

funeral director

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within 24 hours at To the Funeral C Hospital

41

certificate

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After 1

or Attending IF FEMALE: 23b. Was decedent pregnant

28a. Date of Injury (Month, Day

28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred

27. Manner of Death **Natural** Natural 2 Accident 3 Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) 2001

State Registrar

latthe 31. Date filed (Month, Day, 22 32. Registrar's

9000 Frankl

		Please Type or Print in Black Indelib amend item 10e per fh 9867 5- State of Maryland / Departme	ole Ink. Ensure All C	Copies Are	e Legible.
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		Registrar 1. Decedent's Name (First, Middle, Last)	2.	Date of Death	3. Time of Death
Physicia		Thomasina Williams	A	Month PRIL	29 2007 13:50 M
/Medica Examine		4a. Facility Name (If not institution, give street and number) 4b. Ci	ty, Town, or Location of Death		4c. County of Death
		SINAY HOSPITAL OF BALTIMORE BA	PUTIMORE CIT	V	N/A
Funeral Director		5. Social Security Number 215 52 3304 6. Sex 1 I M XXXF 84 Yrs.		Date of Birth (Month, Day, Yes	ar) 9. Birthplace (State or Foreign Country) 1923S. Carolina
p >		Usual Residence of Decedent 10a, State 10b, County 10c. City, Town or Location			10d. Inside City Limits
laryla shov	5	Maryland N/A Baltimore			1 Yes 2 No
the N 28a-1	ect	Mary range 117 22	Zip Code	10g.	Citizen of What Country?
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	0.5	1216		USA
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uld be f Mental H Irked of	To Be	Benjamin Davis	Edna Pick	ett Mo	bley
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Pauline Gray / Daughter 19b. Mailing Addr	ess (Street and Number or Rural Rocerle Dryt. 304	Balti	more, Md 21215
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mit. F sartm sortar / inju		21. Signature of Funeral Service Licersee 22. Name	and Address of Facility Chat	man-Ha	rris FuneralHome
permit Depar Impor any in		Seas Have 5240	Reisterstown	Rd Bal	timore, Md 21215
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occu 2 Medical Examiner: On the basis of examination and/or investige and manner stated.	rred at the time, date and place, an attion, in my opinion, death occurred	d due to the caus at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
o the o the o the o the o the o the o the	Med	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
F≯Fŏ		> Catral IMD	N64671	AT	PRIL, 29, 2007
10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
Y		GABRIELA SZABOLMO SILLA H	ospital of	BALT	MORE
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10:45 A™ May 2007 Regina Yeager Mary /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 10 sto atonsville timore Jary # Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕶 F 80 Yrs. MD 216-22-6922 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. It a Macdigal Examiliar mant be notified at once. 1 ☐ Yes 2 ☐ No Directo Baltimore Catonsville Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 USA 707 Maiden Choice Lane Apt. 8T04 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Anne Arundel Co. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Public Schools Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William Yeager Mary Μ. Christ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2695 Thompson Drive, Marriotsville, MD 21104 Michael F. Summers Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 03 May 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part : Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, tmmediate Cause (Final disease or condition resulting in death) Vascular nerosc **Physician** lerotic /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical attending physic IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 4 Yes 2 4 No 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Id be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate 1 Yes 2 3 NO Be 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 sidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ۵ this After thi funeral o 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the f 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 0054 Q n who completed cause of death (Item 23a) (Type, Print) 31. Date filed Manth. 32. Registrar's Signature State Registrar

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regory Allen Your		State of State	of Maryland / Depar	tment d ificate d	of Health and of Death	d Mental Hy		No	
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Physician/ ledical Examine			Δ		You	ng	Month I April 25, 20		1629 hrs
1	4.	Gregory a. Facility Name (if not institution, give				Location of Death		4c. County of De	eath
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Funeral	5	Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Day	1.0	1	Fo	oreign Country) MD
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with to 23a se not		1. Mantal Status	12. Was Decedent Ever in U.S	S. 13. V	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A White, e	merican Indian, Black, tc.
or items 23	<u> </u>	1 Never Married 2 X Married	Armed Forces? 1 Yes 2 X No					0	Dia ala
after	<u>-</u>		If Yes, Give Year or Dates:	16a Dagge	Yes 2X No dent's Usual Occupa	specify:	ork done	Specify: 16b. Kind of Busin	Black ess/Industry
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d with	Completed	17. Father's Name (First, Middle, Last)				18.Mother's Name		laiden Surname)	
21215-0036 build be filed within 72 hours after Mental Hygiene. marked other than "natural"; te even; the Addical Examiner.	å l	Raymond Young				Mary D		han City on Town	State Zin Code)
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Ore,		1 Burial 2 Cremation 3	Removal from State	crematory or	r other place)	- 1	///07	Daltim	bM ozo
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Baltimore, MI permit. Pages 1 and 2 to Department of Health a Important: If tiem 27 injury or other traum	1	21. Signature of Funeral Service Licen	V. (h,)	1/	2. Name and Addre March F/ 1300 Wab	seh Ave	, Balt	imore,	Md 21215
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aminer		or condition resulting in death)	Due to (or as a consequence of	f): gast:	rointestina	1 hemorrhag	е		
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and	ਜ਼⊦	X UNPENDED	AMENDEDOT OO C	ME	0007 5/1/	O7 (III)			
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the de	를	Part II. Other significant conditions		resulting in	the underlying caus	e given in Part I.	23e. Did to	obacco use contrib	ute to the cause of death?
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of Vit ing Physic After this	ı: To	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time	· · · L _	njury at Work?	28d. Describe	how injury occurre	d
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Visi	ifica	3 Suicide 6 X Could no	t be 28e. Place of Injury - At		, street, factory, offic	e building, etc.	28f. Location	(Street and Numbe State)	r or Rural Route Number, City 5, Westminster, M
Division of the pital of the ours after do ours after do ours after diffiled in by	Certification:	4 Homicide determin	(-)						
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for use		29a. Certifier 1 Certifying Physical Cone) 2 Medical Examina	cian: To the best of my knowle er:On the basis of examination	dge, death and/or inve	occurred at the time estigation, in my opir	e, date and place, ar nion, death occurred	at the time, date	e and place, and du	ue to the cause(s)
To the within To the comp	Medical	29b. Signature and title of certifier	and manner stated.			ense number			ed (Month, Day, Year)
	<	10/ 110	7/17		0.	C.M.E.		April 26, 20	07
		30. Name and address of person who	completed cause of death (Ite	m 23a)					
Ø			sistant Medical Examine	r 111	Penn Street, B	altimore, MD 2	1201		
	ate	31. Date filed (Month, Day, Year) 20	7 Registrar's Signa	ture					
Regist	trar	MAIDOZO							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Roger Dale Aheron April 2007 12:03 P ^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ft. Washington Hospital Center Washington <u>Prince George's</u> Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 6. Sex Months Days Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral Hours 1 X M 2 □ F 59 North Carolina Director 241-76-5810 12-23-1947 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Charles <u>Indian Head</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3805 Marvin Drive Funeral 20640 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If them 27 is marked other the any injury or other traumatic event, the ans. Steamfitter Union 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joe William Aheron Louise Lucile Rickman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna G. Aheron - Wife 3805 Marvin Drive, Indian Head, MD 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gdns: 4-21-2007 Waldorf, MD 21. Signature of Funeral Service 22. Name and Address of Facility 3035 Old Washington Road Huntt Funeral Home Waldorf, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 2 ☐ No the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy perform certificate Division or Vital 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 201 No 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) e Hospital or Attending Ph 124 hours after death. e Funeral Director: After th 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) use of death (Item 23a) (Type, Print) 404 Charles St, La Plata, MD 20646 31. Date filed (Month, Day, State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Adkins Richard Louis 2007 04 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death. 4b. City, Town, or Location of Death Examiner Hicomics PINIASULA SALISBURY Modera REGIONAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1 M 2 □ F 219-36-5448 66 Director 5/15/1940 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Pittsville **Funeral Director** Maryland Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21850 6250 Perdue Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Bace - American Indian 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Army Year or Dates Army 1 Never Married Married 1 ☐ Yes 2 🗓 No Specify: white Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Petroleum Pump Inspector Pump Manufacturer snould be filt and Mental Hv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be iment of Health and Menta tant: If item 27 is marked Oscar T. Adkins Edith Phippin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 6250 Perdue Rd., Pittsville, MD 21850 Edith Adkins/wife permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State Springhill Memory 4/17/07 4 Donation 5 Other (Specify) Hebron, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Zan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** WEEKI disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performe 2 No 1□ Yes or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D29168 M. D ROBERT ALLEN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MA DIVISION 57, ALISBURY 31. Date filed (Month, Day, Year) APR 18 2007 32. Segistrar's Signature State Walne Registrar

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E	S. Agreement	9	Hegistrar 1. Decedent's Name (First, Middle, Last)		rimoate of Boatif	2. Date of De	eath	3. Time of Death
	Physici /Medic		STEPHEN JAMES BROSCO			APRIL	2 ^{Day} , 200 ⁷ 7	5:30A M
No.	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of	f Death	4c. County of Death	
		70	9200 MIMOSA DRIVE 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	LA PLATA If Under 1 Year If Under 2	24 Hrs. 8. Date of Bir	th CHARLES	place (State or Foreign
	Funeral Director		566-39-1837 ¹ √ M 2□ F	4 3 Yrs.	Months Days Hours	8. Date of Bir (Month, Da 1 - 2 - 1	964 ENGL	AND
ASS.	pu »		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation	•		10d. Inside City Limits
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	the N 28a-	rect	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cour	ntry?
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	tems ter mu	Funeral Director	11. Marital Status 12. Was Decedent E Armed Forces?		Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican	gin? (Specify Yes or No , Puerto Rican, etc.)	14. Race - Americ Black, White,	
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215-0036	'2 hou natura Ical E	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most	of working	16b. Kind of Business/In	dustry
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	1	matory or other place)		,	
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	ed for	sicia	In the past 12 months? 1 □ Yes 2 □ No 4 □ Pregnant at		Other (specify)		Month	Day Year
P.0	hat the d by tl letach		9 ☐ Unknown Part II. Other significant conditions contributing to death but	t not resulting in the u	nderlying cause given in Part I.	23e. Did t	obacco use contribute to t	he cause of death?
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or/	<u>></u> .g o	ျ	1 ☐ Yes 2 ☐ tho ☐ Hospital: 1 ☐ Inpatier 27. Manner of Death ☐ 28a. Date of Injur				dence 8 Other (Specific how injury occurred	(y)
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	ro the within Fo the	Med	29b. Signature and title of certifier		29c. License number	~ ~	29d. Date signed (Month,	Qay, Year)
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•	le		30. Name and address of person who completed cause of de	ath (Item 23a) (Type	Print)	11 111	106001	
		to	31. Date filed (Month, Day, Year) 32 Registra	r's Signature	10 de	VUU	50040	
	Sta Regista		MAY 0 3 2007	, Il Go	Will !			

Registrar DHMH 17 Rev 1/2001

07-03234 Emliy Rose Bosley

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			- For State egistrar		Cert	ificate of	Death					Reg. No.		- 10	T (D (
1e	Physicia Examir	n/ ner	I. Decedent's Name (First, Middl EMI	LY	ROSE		SLEY				Date of De Month April 28,	Day 2007	Year		Time of Death 0109 hrs
		4	4a. Facility Name (if not institution Harkins Road / Amos		umber)	4	b. City, Tov Norrisv		ocation of I	Death		1	. County of larford	Death	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under	1 Year	If Under	24Hrs.	8. Date of B	Birth(MM/	DD/YYYY)	9. Birthpl	ace (State or
	Funeral Director		220-25-4340	1M 2_K	1	7 Yrs.	Months	Days	Hours	Min.	11/1	4/1	989	Foreign Counti	y) MD.
		—	Usual Residence of Decedent		10c City	Town or Location	n .							10	d. Inside City Limits
	Maryland 28a-f show any d at once,	- 1	10a. State 10b. County Penna	York	Toc. Oity,	10411 07 2000.			Fawr	ı Gı	cove			1	Yes 2 X No
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	death with the Maryland or items 23a or 28a-f sho	Director	123 Day	Road					321						tates
	with ms 23 be no	ara	11. Marital Status	12. Was De	ecedent Ever in U.S	S. 13. Was	Decedent	of Hisp Cuban,	anic Origir Mexican, F	n? (Spe Puerto R	cify Yes or Nican, etc.)	NO-	14. Race - White,		n Indian, Black,
	more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rate of Health and Menell Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Funeral	1 X Never Married 2 Nover Marr	vorced If Yes, Give Ye	2 X No		Yes 2						Specify:	W	nite
	ural"	화	15. Decedent's Education (Spe	or Dates:		16a. Deceden	t's Usual O	ccupation	n (Give ki	nd of wo	ork done	16b.	Kind of Bus	iness/Ind	ustry
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9	15-0036 filed within 72 I Hygiene. d other than ' t, the Medical	Completed	12		0		Stu	der	t				High	Sch	1001
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3	21215-0036 puld be filed within 7 Mental Hygiene. marked other than ie eveut, the Medica	B	Donald 19a. Informant's Name/Relation	George	Bos	19b. Mailing	r.	/Street	DOI	ma per or Ri		ail		Cro	
1	Baltimore, MID 21215-U036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Insportant: If item 27 is marked other than "natural", injury or other traumatic eveut, the Medical Examiner.	٩	Donna G. Pi	atoria	(Mother	7 23	Dav								
	and 2 ealth iem 2 traun	ŀ	20a. Method of Disposition		20b. I	Place of Dispos	ition (Name	e of cerr	etery,		Date	20c.	Location -	City or To	own, State
	Baltimore, bermit. Pages I ar Department of Hee Important: If ite		1 X Burial 2 Cremation 3 Removal from State crematory or other place) A Departies 5 Other Specific Bel Air Mem. Gardens 5/2/2007 Bel A									ir.	Maryland		
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	ysician		23a. Part I. Enter the disease, of failure. List only one caus	r complications that	caused the death	. Do not enter t	he mode o	f dying,	such as ca	ardiac or	respiratory	arrest, sh	nock, or hea	art	Approximate Interval Between Onset and
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			1 1/	1 1				O.C.	M.E.			A	pril 29, 2	007	
			30. Name and address of pers	on who completed	cause of death (Ite	m 23a)		_						-	
	4		Mary G. Ripple MD.	Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201											
		State	31. Date filed Month, Day, Ye	Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, IVID 21201 Date filed Mary Day, Year 2007 32 Registrar's Signature											

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death April 16, Day 2007 Year **Physician** Vincent Anthony Bowes 8:50 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Charlotte Hall Veterans Home St. Mary's Charlotte Hall If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y July 11, 9. Birthplace (State or Foreign **Funeral** Year. Days Hours 1917 Washington, DC 1⊠M 2□F 89 Yrs. 579-01-6635 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or iteme 23a or 28a-f show the Medical Examiner must be notified at St. Mary's Maryland Charlotte Hall 1X Yes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29449 Charlotte Hall Road 20622 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 图 Porces? 1 图 Yes 2 □ No WWII If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: ģ 3 ☐ Widowed 4 ♣ Divorced nature Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry f Health and Mental Hygiene. Item 27 ie marked other then other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrician Bowes Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Health and Mental Heant: if Item 27 is marked oth jury or other traumatic event William Bowes Mary Monaco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Okrak - Nephew 13337 Colonial Rd., Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery4/19/2007 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Deportment of Important: if any njury or once. Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenter 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 MOTHAI 23/ Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) differentiated Adenocarcinoma of colon **Physician** /Medical Examiner due to rectal bleeding Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed rogressive Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peen enous thrombosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yena Cava Filter this certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to mexaminer? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 3□ DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death.
Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital c within 24 hours af To the Funeral DI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number D45092 ed cause of death (Item 23a) (Type, Print) 205 Prince State Registrar

07-02934 Randy Alan Brooking

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2007 [433]

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	Reg		ate rar	31. Date filed (A	1920	107	Teres	ر میر	ar's Signatu	pares										

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14	Physici		Decedent's Name (First, Midd DEBORAH	le, Last) BAX	TER					2. Date of Dear Month APRIL		2007	3. Time of Death 10:23A N
	/Medi Examir		4a. Facility Name (If not institution WASHINGTON		,	ΓAL	4b. City, Town, o					nty of Death	Y
	Funeral Director		5. Social Security Number 579–74–3458	6. Sex 1 ☐ M 2 ∑ F		. last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, MAY 18	Year) 1957	Cour	nlace (State or Foreigntry) IINGTON, DC
IIIU K I K I S-00000	8a-fahow utified at	Director		CE GEORGE'		ity, Town or Lo	RAINER				0- 0%		Od. Inside City Limits 1 X Yes 2 □ No
t diwith t	23a or a		10e. Street and Number 4224 30th STR	EEŢ		-1-	_	0712			0g. Citizen o	. A .	
oco	al', or iteme Examiner m	by Funeral	11. Marital Status 1 (X)Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	ned 1 ☐ Yes	2 XNo	1	Was Decedent of H ff Yes, specify Cuba 1 ☐ Yes 2 X No	lispanic Or an, Mexical Specify:		ecify Yes or No- Rican, etc.)		ace - Americ lack, White, cify: I	
0-6121.	nd Mental Hygiene. marked other than "natural", or iteme 23a or 28a-f ahow imatic event, the Medical Examerer must be multied at	Completed		nt's Education est grade completed) College (1	-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during mos d)	st of work	ng	16b. Kind of	Business/Ind	•
	hental Hygirked other	To Be Co	17. Father's Name (First, Middle, ROBERT S. BA	Last)						First, Middle, I		ame)	
s, maryid	0 .00 E		19a. Informant's Name/Relation: OPHELIA BAXTER				ng Address <i>(Street</i> 4 30th ST						20712
	ant and		20a. Method of Disposition 1 □ Burial 2 ②Cremation 4 □ Donation 5 □ Other (3	Specify)	State	cemetery, cre.	osition (Name of matory or other place E CREMAT(2. Name and Addre	ORY	4/19	/07		ALE,M	own, State ARYLAND RAL HOME
	Depa impo any ic		K.D.	y-hall		3	7474 LANI	OCVER	ROAI	LANDOV	ER, MAI		20785
	hysician /Medical xaminer		23a. Part1. Enter the disease, shock, or heart failure. Is immediate Cause (Final disease or condition resulting in death)	a Due to	ach line.	quence of):	11			and bemop			Approximate interval Between Onset and Death
O, axacutad	physician and ithe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Status Due to	or as a conse or as a conse	chest tub quence of):	oe placement			PROVED BY MEN	e LUI		
do rou,	g physici as the bu	ledical		d. Post r	ulmonary	decorti	cation	CERTIF	CATIONA	PROVED S.			
The law requires that the death certificate he executed	been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 ☐ Fet ant at time of	al death 3	Ectopic pregnancy Other (specify)				23d. [Date of delive Month	ery Day Year
order, r	en signed b	þ	Part II. Dther significant conditi	ons contributing to de		sulting in the u	nderlying cause giv	en in Part I	l. 	1	bacco use co es 2 □ No		ne cause of death?
inal nec	ficate has b	e Completed	morbid obesity; 25. Was case re e to medica	asthma							med? 2 🗆 No	prior to con death?	psy findings availabing pletion of cause of
Physicia	r this certi	To B	examiner 2 1 Ves 2 No 27. Manner of Death	Hospital: 1		ER/Outpatie		er: 4 🗆 Nu	ursing Ho	me 5 ☐ Reside 28d. Describe ho	ence 6 🗆 C		y)
DIVISION VICE	within 24 nours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could 4 Homicide determ	not be nined 28e. Place buildi	of Injury - At I	Injury unk	Wor	k? Yes 2.□ 7	No	Lung punct chest tube	tured du	ring p	lacement of Al Route Number, Park, MD
J Jenital	24 hours al e Funeral D etely filled i	edical Ce	29a. Certifier 1 Tcertifyi (Check only 2 Medical	ng Physicien: To the Examiner: On the b and man	best of my kn	nowledge, deat nation and/or in	h occurred at the tir vestigation, in my d	ne, date ar pinion, dea	nd place,	Washington and due to the ca ed at the time, d	n Advent ause(s) and i	manner as si	spital tated.
Toth	To the	Me	29b. Signature and title of certific	m	a of dooth (to	220) (Tuno	29c. Licens	e number	14.	7 2	9d. Date sign	ned (Month,	Day, Year)
	(6)		Nasreen M. K 31. Date filed (Month, Day, Year	ango M.D.	7610	Carro	lle Avenu	e # 2	05 T	akoma Pa	ark, M	arylar	nd 20912
DHA	Sta Regist		APR 1 9 200	7 fieren	A.	bout	,						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Engure All Co

/sician	Registrar	me (First, Middle,	(act)		Certifica	te of	Death		Reg. No.		
	Iona		_					2. Date of De Month	Day	Year	3. Time of Death
ledical		Vere	Barnes give street and numb	er)	4h Cit	v Town o	r Location of De	April April		2007 unty of Death	10:07 A
aminer			and Hospit			into		ratii		nce Ge	orgo!a
-	5. Social Security		S. Sex 7.	Age (In yrs. last bi	rthday) If Und	er 1 Year	If Under 24 H				place (State or Foreig
r	365-38-6 Usual Residence		1 □ M 2 🕅 F	70	Yrs. Months	Days	Hours M	in. (Month, Da 7/29/1	y, Year) 936		his, TN
	10a. State	10b. County		10c. City, Tov	n or Location					1	0d. Inside City Limits
neral Director	DC			Washir	gton						X Yes 2 □ No
Funeral Director	10e. Street and N	umber				ip Code			10g. Citizen	of What Cour	itry?
[a]	603 At1	antic St	reet SE			20032	2		USA		
une	11. Marital Status		12. Was Decede Armed Force	es?	13. Was Dec If Yes, sp	edent of H	lispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. F	Race - Americ Black, White,	
by Fi		rried 2 Married	If Yes, Give	_	1 🗆 Yes		Specify:			cify:Blac	
d D	3 K1 Andowed	4 Divorced	Year or Date								
Completed		15. Decedent's ecify only highest	grade completed)	168	. Decedeni's Us (Give kind of w	ual Occupi rork done d	ation during most of v d)	vorking	16b. Kind o	f Business/Inc	dustry
Ę	Elementary/Sec	ondary (0-12)	College (1-4)		gistere				11 1	1	
	17. Father's Name	e (First, Middle, La	<u>.</u>	IXC	giscele	u Nul		lame (First, Middle,	Healt Maiden Sun		
To Be	Harry Ri	.ce						la Cutler		,	
-	19a. Informant's	Name/Relationship	(Type, Print)	198	. Mailing Addres	ss (Street a		Rural Route Numbe	er. City or Tox	wn. State. Zip	Code)
	Jeffrey	L. Barn	es (son)					ad Laure			,
	20a. Method of Di	•		comoto	f Disposition (Na ry, crematory or	ame of	1	Date	20c. Locatio	on - City or To	wn, State
		2 ☐ Cremation 3 5 ☐ Other (Spe	☐Removal from Sta	110			'	23/2007	Bront	wood, l	MTD
		uneral Service Lic	censee	.10				Fort Linco			
	Souga	Moutan	rees. Che	allare				Road I			
	23a. Part1. Enter	the disease or co	omploations that causely one cause on each								Approximate
	Immediate Cause	(Final		ıte Myoca							Interval Between Onset and Death
	disease or condit resulting in death	on)	a	as a consequence		шатс	LION				
			00 00 (01	as a consequence	oi).						
er	Sequentially list of if any, leading to cause. Enter Und Cause (Disease of	onditions, immediate	b. Due to (or	as a consequence	of):						
i	Cause (Disease of that initiated even	eriying ir injury ts									
Examiner	resulting in death)	Last	Due to (or	as a consequence	of):						
ca			d								
led			337								
20	IF FEMALE: 23b. Was decede		23c. If yes, outcom	ne of pregnancy 2 Petal death	3 ⊟Ectopic p	arognanov.			23d.	Date of delive	ry
<u><u></u></u>	in the past 1:	No	4☐Pregnant	at time of death	5 ☐ Other (s					Month	Day Year
Physician/Med	9 ☐ Unknow		9□ Unknown								
by F			contributing to death	but not resulting in	the underlying	cause give	en in Part I.	23e. Did to	bacco use co	ontribute to th	e cause of death?
ed	End sta	ge Renal	Disease					1 🗆 Y	es 2 🕅 No	3 Proba	ably 4 □Unknow
Completed by								24a. Was		b. Were autop	osy findings available
é								autop perfor	med?	prior to con death? 1 ☐ Yes	npletion of cause of
De	25. Was case refe	rred to medical					26. Place of D	1 ☐ Yes eath (Check only o		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2L NO
	examiner? 1X Yes 2] No	Hospital: 1 ☐ Inpa	atient 2 X ER/Ou	tpatient 3 D	OA Othe		Home 5 ☐ Resid		Other (Specify	1)
2	27. Manner of Dea		28a. Date of Ir (Month, I	jury 28b. 1		28c. Injury Work		28d. Describe h			/
	1 🗀 (Natural	5 Pending investigation		say reary	М		Yes 2 □ No				
	2 Accident	6 ☐ Could not	28e. Place of	Injury - At home, fa etc. (Specify)	rm, street, factor	ry, office		28f. Location (S	treet and Nui	mber or Rural	Route Number,
	2 Accident 3 Suicide	datamina	bollding,	etc. (Opocny)				City or Tow	ri, State)		
Certification: To	2 Accident	datamina				at the tim	e, date and pla	ce, and due to the c	ause(s) and	manner as ets	ated.
Certification:	2 Accident 3 Suicide	determine	Physician: To the be aminer: On the basis	or examination an	n, death occurred d/or investigation	n, in my op	oinion, death oc	curred at the time, o	late and place	e, and due to	the cause(s)
Certification:	2 Accident 3 Suicide 4 Homicide	determine	Physician: To the be aminer: On the basis and manner	or examination an	uvor investigation	n, in my op	oinion, death oc	curred at the time, o	late and place	e, and due to	the cause(s)
Certification:	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	determine	arimiter. On the basis	stated.	29	n, in my op	number	curred at the time, o	late and place 29d. Date sign	e, and due to ned (Month, L	the cause(s) Day, Year)
	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signalure and	determine 1 **X Certifying F 2 ** Medical Exit	and manner	stated.	29	c, License	number	curred at the time, o	late and place 29d. Date sign	e, and due to	the cause(s) Day, Year)
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Certification:	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and	determine 1 **X Certifying F 2 ** Medical Exi d title of certifier fress of person who Palmer,	and manner	f death (Item 23a)	Type, Print) Avenue,	ic. License	number	curred at the time, o	29d. Date sign	e, and due to ned (Month, £	the cause(s) Day, Year)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 2.00 PM **Physician** Richard Arthur BRUST 2007 /Medical 4c. County of Deat 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Funeral Year Days Hours 1 XM 2 □ F 82 30,1924 Ohio 295-18-9674 Dec. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" any injury or other traumatic exercises. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Washington Maryland Hagerstown Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12155 Walnut Point West 21740 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 10/2 11. Marital Status 1 ⊠Yes 2 no 194345 If Yes, Give Year or Dates: W.W.II Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No white Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) plumber/pipe fitter commercial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Arthur Jacob Brust Marie Alta Carpenter ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Josephine Brust - wife 12155 Walnut Point West, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Hagerstown Crematory Hagerstown, Maryland 4 □ Donation 5 □ Other (Specify) 2007 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 Fred L. Vester 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician minute /Medical Due to (or as a consequence of): Examiner ear wteriosclevel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9∏ Hnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy perform or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 | Inpatient 2 P/Outpatient 3 □ DOA 2 After this 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation in 24 hours after control the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 5H 35+1 Year) 31. Date filed (Mor State 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death SAILEY **Physician** Month 1:43 p.M 16 VIAD 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Nursing Home Manoe 20merse 1 anokin rinc Year If Under 24 Hrs HUME 700 5. Social Security Number If Under 1 6. Sex 8. Date of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) **Funeral** 88 Days Hours Min 1 M 25 F 144-18-9712 Yrs. Director 02-05-1919 Usual Residence of Decedent the Maryland 10b. County 10a. State 100 City, Town or Location 10d. Inside City Limits Examiner must be notified at MD 1 No 2 No rincess Director DomerseT 10e. Street and Numb 10g. Citizen of What Country? 10f, Zip Code 5 21853 U.S.A 30480 238 າດ∈ 20011death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married ō Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black ð 3 Widowed 4 □ Divorced "natural". leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than "natur 15 Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Compl Elementary/Secondary (0-12) College (1-4or 5+) Domesti C 1142 aborer 7 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mental Bankhive Waters Mindella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bronk, NY 1505 ARCHER RD APLIB 10462 Johnson f Health itam 27 I 20a. Method of Disposition - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o Burial 2 ☐ Cremation 3 Removal from State CEntennial Compley 04-22-2007 fairmount MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Athrony E. Ward Funeral Hemo 21. Signature of Funeral Service Licensee 30639 Hampden Ave. Princess UP 21853 Anne, and 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Syears Privsician emphysma disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed iding physician and ise as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten 3 Ectopic pregnancy ō in the past 12 months? Dav 4 Pregnant at time of death , the the 5 Other (specify) yes 2□No 9☐ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has e 2 autopsy rector, page 2 performed? 2□ No 1 TYes 2 1 No Division of Vital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Tes Hospital: Other: 2 **☑** No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending 1 ☐ Yes 2 ☐ No death. М investigation I Director: / d in by the fr 2 ☐ Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗀 Homicide Fo tha Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of fertifier 29c. License number 29d. Date signed (Month, Day, Year) DOJ7 359

Registrar

State

ORIGINAL

1415.5.

DIVISION ST.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DK: USHA

APR 1 9 2007

31. Date filed (Month, Day, Year)

NATESAN

32. Registrar's Signature

		1	State State Registrar	of Maryland / Depr iy G867 5/25/07 Cer	artment of H rtificate of L	ealth and N Death			14336
			1. Decedent's Name (First, Middle, Last)				2. Date of DeathAp	r.21,2007	3. Time of Death
	sicia edica	_	Denise Clas	rke				2007	1:20A M
	mine		a. Facility Name (If not institution, give street and	number)	4b. City, Town, or	Location of Death	4	c. County of Death	
		34.	3818 Iron Gate Lane	9	Bowi		1	Prince G	eorges
Fune Direc			5. Social Security Number 6. Sex 1 3 1 - 4 0 - 79 3 7	7. Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea April 23	r) Cour	place (State or Foreign ntry) V
P.			Jsual Residence of Decedent						
ırylar bhow	3	_	10a. State 10b. County	10c. City, Town or Lo	cation			1	0d. Inside City Limits 1 XYes 2 □ No
e Ma		5	Md. PG	Mitchel]	lville				
it to			10e. Street and Number		10f. Zip Code		10g. C	citizen of What Cour	ntry?
ath w	1	<u>a</u>	3403 Woodridge Cour			721		nited St	
UU36 hours after death with the Maryland tural; or Items 23s or 28s-f show		Funeral Director	Armed		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
rs aft		by	If Yes,	es 2 X No Give or Dates:	1 ☐ Yes 2X No	Specify:		Specify: Bla	ck
27275-0036 d within 72 hours af giene. ar than "natural", or		ed	15. Decedent's Education	16a, Dece	dent's Usual Occupa	ation	16b.	Kind of Business/In	
within 72 ene. then nat	1	Completed	(Specify only highest grade complete Elementary/Secondary (0-12) Colleg	ee (1-4or 5+) (Give life.	kind of work done a DO NOT use retired,	luring most of work)	ring		
T the et a		E	4		Troubl	eshoote	r P	rivate	
e filed other	, and	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, Maide	an Sumame)	
arylan should be ind Mental		9	Clifford Simpson			Creola	Coope	<u> </u>	
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. The marked other then "naturel", or thems 23s or 28s-f show	omer traumanc		19a. Informant's Name/Relationship (Type, Print)				al Route Number, City	or Town, State, Zip	Code)
2 0 5 5 4	=		David Bennett/son	Bale	1 Botany	27616			
Baltimore, permit. Pages 1 an Department of Heal Important: If Item 2	100		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal free	20b. Place of Dispo cemetery, crer	osition (Name of matory or other place		Date 20c.	Location - City or To	
Pages ment of	n d		4 □Donation 5 □Other (Specify)	Riverdal				Riverda	
Balt permit. Departr Import	eny in		21. Standard of Funeral Service Licenses	22	2. Name and Addres	s of Facility H	odges & E	dwards	F.H.
ದ ೩೭೯೪	a		Janes Edu				Rd.,Suit	land,Md	
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. Do not ent on each line.	ter the mode of dying	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Driset and Death
Physic			Immediate Cause (Final disease or condition	resputety	an	T			Briser and Beatin
/Medi Examir			resulting in death)	to (or as a consequence of):	came				
LAdilli			Sequentially list conditions, b.	nauen	came				
. S. C.	ii.	Examiner	if any, leading to immediate Due cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of):					
	I-tran	хап	that initiated events c	to (or as a consequence of):					
cate be executed physicien and									
Ph cat	Š	edicai	d						
. Box 6 death certifit e attending p	es es	Z/M		outcome of pregnancy				23d. Date of deliv-	ery
Beath Beath	101	ciar	in the pact 12 months?		□Ectopic pregnancy □ Other (specify)			Month	Day Year
	acne	Physician/M	9 ☐ Unknown 9 ☐ Ui	nknown					
	9 9	by P	Part II. Dther significant conditions contributing t	to death but not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobacci	use contribute to t	he cause of death?
rds quire an sig							1 🗆 Yes	2 No 3 ☐ Prol	pably 4 □Unknown
aw requires been signed.	suo	piet					24a. Was an	24b. Were auto	opsy findings available impletion of cause of
The it	age	Completed					autopsy performed?	death?	2⊠ No
Ta ::	tor.	0	25. Was case referred to medical			26. Place of Dea	th (Check only one)		
yeic nis ce	direc	ToB	examiner? 1 ☐ Yes 2X No Hospital: 1	☐ Inpatient 2 ☐ ER/Outpatier	nt 3 DOA Othe	er: 4 Nursing H	ome 5 Residence	6 Other (Special	(y)
Division of Vital Records, to attending Physicien: The law requires that death. Director: Attentis certificate has been signed.	neral	Ä	27. Manner of Death 1 Natural 5 Pending (A	ate of Injury 28b. Time of Injury Injury	f 28c. Injury Work	/ at k?	28d. Describe how in	jury occurred	
or: A	De 10	Satic	2 Accident investigation			Yes 2 □ No			
IVIS r Att	l by t	Certification:	3 Suicide 6 Could not be determined 28e. P	lace of Injury - At home, farm, str uilding, etc. <i>(Specify)</i>	reet, factory, office		28f. Location (Street City or Town, Sta	and Number or Run ite)	al Route Number,
Division of Vital Rec To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this centificate has	= De								
Hosp 4 hou Fune	9 1	edicai	(Check only 2 Medical Examiner: On the	the best of my knowledge, deat ne basis of examination and/or in					
the the	ed E	Med	29b. Signature and the of certifier	nanner stated.	29c. License	e number	29d [Date signed (Month,	Day, Year)
T with	8	-	1	MI		21216	253.	4/04/	=4
•	. 1		20 Name and address of access the access the	course of death (from 22s) (T		ر) در ه		71000	
	4		30. Name and address of person who completed of the compl		rank)				
7 15 15 W. W.	Sta	e.		Registrar's Signature	ach E				
Re	gistra		31. Date filed (Month, Day, Year) 2007	Topus Is for	A STATE OF THE PARTY OF THE PAR				

			For State Registrar	State of Marylan		artment of F <i>tificate of</i>		id Mental H	ygiene Reg. No. 2	007		337
Tig			1. Decedent's Name (First, Middle, Last	")				2. Date of 0 Month	Death Day	Year	3. Time of	Death
ŀ.	Physici /Medic	_	Willie C.	Cook				April			1:00	pM
ì	Examin	-	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of E			nty of Death		
ZA.		1	1907 East-West Hi				lver Sp			ntgome		
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		Min. (Month, I	Day, Year)	Cou	place <i>(State</i> o. ntry)	r Foreign
	Director		253-66-1495 Usual Residence of Decedent	63	113.			Aug.	28, 1943	3 G€	eorgia	
	and w		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					10d. Inside Cit	ty Limits
	Mary f sho ied a	ō	to a second district		~	a !					1 ☐ Yes	2 ☑ No
	28a	Director	Maryland Mont 10e. Street and Number	gomery	SIIV	er Sprine 10f. Zip Code	g		10g. Citizen o	of What Cou	ntry?	
	3a ol		1907 East-West H	Highway Ant.	103	20910			USA			
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?			lispanic Origin	n? (Specify Yes or I		lace - Ameri		
9	after or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1≹¥es 2 ☐ No If Yes, Give		r res, specily Cub 1 □ Yes 212 No		rueno rican, etc.)		lack, White,		
8	ral", c	i by	3 ☐ Widowed 4 ☑ Divorced	Vear or Dates:	nown	10 165 24-1140	ореспу.		Spec	cify: Blac	ck	
21215-0036	72 h 'natu dical	Completed	15. Decedent's Edu (Specify only highest grad	ucation	16a. Deced	lent's Usual Occup kind of work done DO NOT use retire	oation during most o	f working	16b. Kind of	Business/In	ndustry	
7	ithin ne. nan ⁺ e Me	lg l	Elementary/Secondary (0-12)	College (1-4or 5+)	1	DO NOT use retire: rvisor	d)		Nat'l (Gallei	cy of A	rt
	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show wit, the Medical Examiner must be notified at	වී	17. Father's Name (First, Middle, Last)		bupe	1 1 201	18 Mother's	Name (First, Mida			., 01	
anc	l be findal Hed of ed of	Be	Champ Cook				l .	lie Maude	· _	,		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	ဥ	19a. Informant's Name/Relationship (T	vne Print)	19b. Mailir	ng Address (Street	and Number	or Rural Route Nur	nber. City or Tow	vn. State. Zi	n Code)	
Za	d 2 s Ith ar 27 Is trau		Beverly A. Cook/Si					Drive, S	-			910
	tem tem		20a. Method of Disposition			sition (Name of natory or other pla		Date	20c. Location			
Baltimore,	Pages nent of H ant: If ite ury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify	Mot		tan Crem		April 23	1		17 da an ai	
Ħ	nit. Fartme		21. Signature of Juneral Service Licens		24	Name and Addre	ess of Facility.	2007 ins Funer			, Virgi	.nra
ã	permi Depar Impor any Ir		> (survey) >	Cole				Blvd, W.,			ng. MD	20901
	w M		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the deal							Approximate Interval Bet	е
	Physician		Immediate Cause (Final	cause on each line.	0						Onset and I	Death
Ž.	/Medical		disease or condition resulting in death)	a. Due to (or as a cover	quence of):	Can	ur	ance.				
	Examiner		Commentation that are different	, Como na	my 1	Arlen	1 a	lisear Lailu	2.			
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	uence of):		1	1.1				
	ecute nd trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	o. Congrel	time	Itea	wh	dailu	<i>∼ ,</i>			
Ö,	e exe	ŭ	resulting in death) Last	Due to (of als a consec	quence of):							
68760,	icate be executed physiclan and s the burial-transit	dical		.d								
			IF FEMALE:	220 Hugo outcome of progn	anou							
Вох	ath c	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet	aldeath 3 [Ectopic pregnanc	·y			Date of deliv Month		Year
o.	the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o 9□Unknown	death 5L	Other (specify) _			-			
P.O.	The law requires that the death certif ste has been signed by the attending page 2 should be detached for use as	P	Part II. Other significant conditions co	ontributing to death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Di	d tobacco use co	ontribute to	the cause of d	leath?
ds,	signe d be	i by						1[∃Yes 2⊟No	3 □ Pro	bably 4 🖼	nknown
Š	v requ	Completed							ae an 24	b Woro aut	opsy findings	available
Rec	has ge 2	ᇤ						au	topsy rformed?	prior to co death?	ompletion of c	ause of
a	n: Ti ficate r, pa		25. Was case referred to medical				00 Di	1□ Yes		1 🗌 Yes	2□ No	
⋚	sicla certi irecto	Be c	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	1 FB/Outnatier	nt 3□ DOA Oth	ner:	f Death (Check onling Home 5		Othor (Coso	(6.4)	
o	Phy er this eral d	2	27. Manner of Death	28a. Date of Injury	28b. Time o				e how injury occ		ny)	
on	th. : Afte	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		rk?]Yes 2	,				
Division or Vital Records,	Atter	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci		eet, factory, office		28f. Location	(Street and Nu Town, State)	mber or Rui	ral Route Num	nber,
	al or s afte	Certification:	4 LI TOTTICIO	building, etc. (Speci	(9)			Oily or	own, State)			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has a completely filled in by the funeral director, page 2			ysician: To the best of my kniner: On the basis of examin								s)
	the H iin 24 the Fi	ledical	one)	and manner stated.								-,
	To To	Σ	29b. Signature and title of certifier	10	hel	29c. Licens	se number	2	29d. Date sig	ned (Month	, Day, Year)	
	10		Sum			- 100	27 46	7)	7/1	010	+	
	•		30 If me and address of person who c	completed cause of death (Ite	m 23a) (Type,	Print)	SUKE	DH K. I	HET/	TN,	MU	
			31. Date filed (Month, Day, Year)	completed cause of death (Itel AVE# 260;	7AKC	MAPAT	a, n	11) 10	112			
	Sta Regist			007	KA	made 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 16,2007 10:00 AM CORRINE COLMES April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elizabeth Ave 216 Rockville Montgomery 8. Date of Birth (Month, Day, Year)
Aug. 20,1937 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 M 201 69 579-54-7878 Director Wash. DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Montgomery Rockville 1 X Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20850 216 Elizabeth Avenue U.S.A. Funeral be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married X Married altimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. is marked other than College (1-4or 5+) 12th Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: if Item 27 is marked any injury or other traumatic evonce. Evans Bobo Ada Miles 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 216 Elizabeth Ave., Rockville, MD 20850 John E. Colmes (Husband (20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Lincoln Cem 4/20/07 4 Donation 5 Other (Specify) Brentwood, MD 22. Name and Address of Facility Snowden Funeral Home Signation of Funeral Service Licer see 246 N. Washington St Rockville, MD20850 No 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myeloid Leukemia vear /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed as the burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 🗷 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy perform 2X No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred al or Attending P after death. I Director: After of in by the funera Injury at Work? After 1 🙀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Registrar

State

29b. Signature and

Leon

31. Date filed (Month, Day, Year) 19

Hwang,

and manner stated.

of person who completed cause of death (Item 23a) (Type, Print)

M.D. 32 egistrar's Signature

To the within 2

29c. License number

D45880

1396 Piccard Drive, Rockville, MD 20850

29d. Date signed (Month, Day, Year) 4/18/07

			Please	Type or Prin							•	
			For State	State of Ma	aryland				Mental Hy	/giene		
			1 - State Registrar	- 43		Certific	cate of	Death	l a Dete ef D	Reg. No.	2007	114339
П	Physici	an	1. Decedent's Name (First, Middle, La	lever					2. Date of D	Day		3. Time of Death 8:21 AM
	/Medic		4a. Facility Name (If not institution, giv			4b.	City. Town. o	r Location of Death	April	23 4c.	County of Death	
	Examin	er	University of Maryle		& Center		Baltim		1		,	
- "	Funeral		5. Social Security Number 6. S		e (In yrs. las		nder 1 Year ths Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth av. Year)	9. Birth	nplace (State or Foreign
D.	Director		220-64-6212	NAM 2LIF	51	Yrs.	Lilo Dayo	Tiodio Nini.	May 5,	1955		sýlvania
	and t		Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Location						10d. Inside City Limits
	Mary -fsho Fied a	to	Maryland Wash	ington		Hage	rstowr	,				1 X Yes 2 ☐ No
4	r 28a r noti	Directo	10e. Street and Number	riigion			. Zip Code	,		10g. Citi	zen of What Cou	intry?
1	23a o		65 East Avenue					21740			USA	
9	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. Was E	ecedent of F specify Cub	lispanic Origin? (Span, Mexican, Puert	pecify Yes or N o Rican, etc.)	0-	 Race - Amer Black, White 	ican Indian,
ဓ္ဌ	s arre	by Ft	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced	1 ☐ Yes 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Vo	1□Y	es XXNo	Specify:			Specify:	\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.
5-0036	should be lied within 7z hours arier death with the maryland nd Mental Hygiene. marked other than "natural" or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	ed b	15. Decedent's E			16a. Decedent's	Usual Occup	ation		16b. Ki	nd of Business/I	White
215	In "na Medic	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5	5+)	(Give kind o life. DO No	of work done OT use retire	during most of word)	king			
21.	giene giene the	E I	10			Р	ainter			Н	ome Impr	ovement
ם	d oth	Be (17. Father's Name (First, Middle, Last					18. Mother's Nan				
y Ya	Men narke	ပ္		ever					Elmira		=	
-	1 CO 00 TE		19a. Informant's Name/Relationship (^{ip Code)} 25419
a)	Health Health Iem 27 i		Mary E. Clever -	Morner	20b. Plac	195 Pot ce of Disposition	(Name of		Date Date	1	cation - City or	Virginia Town, State
ou Ou			1 Burial 2 □Cremation 3 □ 4 □Donation 5 □ Other (Special			netery, cremator an Lawn M	-	· i	26 2007		·	, Maryland
Baltimore,	permit. Prage Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	* :	0.00			represidabilityHom			ramopor i	21795
ñ	Imper any any any any		() Xuth Ch			425 S	. Conc	cocheagu	e St. W	illia	amsport,	Maryland
			23a. Fart1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	I the death. ne.	Do not enter the	mode of dyi	ng, such as cardiad	or respiratory	arrest,		Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	a Ala	فأصمان	Hepa	わか					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequer	nce of):						
		<u>~</u>	Sequentially list conditions,	b Due to (or as	a conseque	nce of):						
7	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
, O	execun and and rial-tra	Еха	that initiated events resulting in death) Last	Due to (or as	a consequer	nce of):						
3760	death certificate be executed e attending physician and id for use as the burlai-transit	Physician/Medical		d								
(687	ing ph	Med	IF FEMALE:									
Вох	ittend or us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal d	eath 3 ☐Ecto	oic pregnanc	y			23d. Date of deli Month	very Day Year
O	by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of dea	tn 5∐Otne	er (specify) _					
, О	iaw requires that the as been signed by th 2 should be detache		Part II. Other significant conditions	contributing to death b	ut not resulti	ng in the underly	ing cause giv	ren in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
Vital Records,	quires n sigr uld be	ed by							1 🗆	Yes 2	□ No 3 □ Pro	obably 4 Unknown
O O	aw require is been si 2 should t	Completed							24a. Wa		24b. Were au	topsy findings available
ř	ate ha	lmo;							peri 1 Yes	opsy formed? 2 No	death?	ompletion of cause of 2 ☐ No
Ita	certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place of Dea				
	this o	유	1 Yes 2 No	Hospital: 1 Impatie			DOA Oth	4 Li Nursing H			6 □Other (Spec	ify)
Division or	ffer	ion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Inju (Month, Day	y Year)	8b. Time of Injury M	28c. Inju Wo	ryat rk? Yes 2∐No	28d. Describe	how injur	y occurred	
)SI	death death ctor: y the	ficat	3 Suicide 6 Could not b	e 28e. Place of inju	ury - At home	e, farm, street, fa		763 2 110	28f. Location	(Street an	d Number or Ru	ral Route Number,
	or ne hospital of Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)				City or To	own, State)	
1	lo the hospital within 24 hours a To the Funeral I completely filled		29a. Certifier 1 Certifying Pl	nysician: To the best miner: On the basis o	of my knowle	edge, death occu	irred at the ti	me, date and place	, and due to the	e cause(s)	and manner as	stated.
1	the Fi	Medical	one)	and manner sta	ated.	ii alid/ol liivesiig	allon, in my		ined at the time	e, uale and	prace, and due	to the cause(s)
F	<u>•</u> ₹ 6	2	29b. Signature and title of certifier	0			29c. Licens	e number		29d. Da	te signed (Month	i, Day, Year)
)			Cirroly Luc	, Mrs		0.) (7	177	760		Hori	123,2	w 7
SH	1 1		30. Name and address of person who Cindy Lee Uni	completed cause of d	eath (Item 2	sa) (Type, Print)	enter 7) of of m	Di -	2250	WITH GR	CEN E STREET
	Sta	te	31. Date filed (Month Day, Year)	32. Registr	ar's Signatur	re	······································	ight. DI 114	acore.	BELDM	ex / I'V	to the cause(s) a, Day, Year) CEN E STREET 2(20)
	Regist	ar	APR 24	2007	en l	4. Soe	BI		10			

			110000	State of Marylan		ent of Health and		-	
			1 - For State Registrar	Otate of Marylan		ate of Death		2007	16360
	. 2	k seg	Negistrar Nededent's Name (First, Middle, Last	it) a	Continue	ne or beaut	Reg. P	10.	3. Time of Death
	Physici		NETTIE	COTTMA	un.			5 2007	9:55 AM
	/Medio Examir		4a. Facility Name (If not institution, give			ty, Town, or Location of Deat		lc. County of Death	
	LAGITI	26	A	s Nursing Ho		risfield		Somer	W.T
	Funeral	-	5. Social Security Number 6. Se	ex 7. Age (In yrs. i	last birthday) If Und	ler 1 Year If Under 24 Hrs.	8. Date of Birth	Q Riethe	place (State or Foreign
	Director		216-09-8217 1	□M 2×F 1C	Yrs. Month	s Days Hours Min.	12-22-18	99	MD
	pu .		Usual Residence of Decedent 10a. State 10b Coopty	10a Cib	v Tourned Leasting				
	aryla ehov	<u>_</u>	112	erset (y, Town or location	1			10d. Inside City Limits 1
	the Marylar 28a-f ehow notified at	ect	10e. Street and Number	er act					
	5 6	Funeral Director	254 Somers Co	us Aot	101.	21817	10g. 6	Citizen of What Cour	ntry? ▲
	eath w	era	11. Marital Status	12. Was Decedent Ever in U.	S 13 Was Day	0 10	necify Ves or No-	14. Race - Americ	can Indian
	ter dea	Fu	1 ☐ Never Married 2 ☐ Marned	Armed Forces? 1 ☐ Yes 2 No	ff Yes, s	cedent of Hispanic Origin? (S becify Cuban, Mexican, Puert	o Rican, etc.)	Black, White,	
036	urs aft	by	3 ✓ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify:	ack
21215-0036	72 hours "natural", roleal Exp	Completed	15. Decedent's Ed (Specify only highest gra		16a. Decedent's U	sual Occupation work done during most of wor	16b.	Kind of Business/In	dustry
21	within ene.	ng l	Efementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retired)		D	MARKER
	filed withir Hygiene. other than	S	641		Las	over	9		WORKER
nd	uld be fil fental H rked oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle, Maid		
Ya	thould be ad Menta marked matic ev	٩	0	man		J ara			
Maryland	S S S S S S S S S S S S S S S S S S S		19a. Informant's Name/Relationship (7			ss (Street and Number or Ru	aral Route Number, City		-
	is 1 and in Health Item 27 other tr		20a. Method of Disposition	20b. Pl	lace of Disposition (A	ardson Ave.		Location - City or To	
JO.	ages nt of t: if it or o		1 ØBurial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crematory o	r other place)	//	Lavion,	
Baltimore,	permit. Pages Department of Important: If II any Injury or o	1	4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen			emetery 04-	21-207		
Ba	Depa Impo any Ir		An line	Dand X	1 214	Cove ST. Cri		1) 2181	neval Hone
	935		23a. Part1. Enter the disease, or comp	olications that caused the death	n. Do not enter the m			12 000	Approximate
lip.	Physician		Immediate Cause (Final	one cause on each line.	Δ	CVD.			Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	a Due to (or as a consequ	- 1				
九	Examiner								
	T	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	uence of):				
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events	c.					
760,	e exection a	Ä	resulting in death) Last	Due to (or as a consequ	uence of):				
876	9 %	dicai		d.					
x 68	ding t	Me	fF FEMALE:	23c. If yes, outcome of pregnar	no.			1	
Вох	atten for u	lan	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	I death 3 ☐ Ectopic			23d. Date of delive Month	ery Day Year
P.O.	the d	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	eath 3 Other	specily)			
	The law requires that the death certifica sie has been signed by the attending ph page 2 should be detached for use as it	Completed by Physician/Med	Part II. Other significant conditions co	ontributing to death but not resu	alting in the underlying	cause given in Part I.	23e. Did tobacco	use contribute to the	ne cause of death?
Records,	quires n sign	Q D					1 🗆 Yes	2 No 3 ☐ Prob	ably 4 Unknown
00	w requir s been si should	lete					24a. Was an	24b. Were auto	nsv findings available
Re	The law	m o					autopsy performed?	death?	psy findings available mpletion of cause of
Vital	sicien: Th certificete rector, pag	Be C	25. Was case referred to medical			26. Place of Dea	1 ☐ Yes 2 X N ath (Check only one)	lo 1 🗆 Yes	2 No
Y	× 5	ToB	examiner? 1 ☐ Yes 2 X No	Hospitaf: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3 1 1	1 04	ome 5 Residence	6 ☐Other (Specif	v)
0	ding Ph h. After thi funeral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. fnjury at Work?	28d. Describe how in		
Ö	Attending or death. ector: After by the funer	atic	2 ☐ Accident investigation		М	1 ☐ Yes 2 ☐ No			
Division of	ter de lrect	€	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Pface of Injury - At ho building, etc. (Specify	me, farm, street, factor)	ory, office	28f. Location (Street : City or Town, Sta	and Number or Rura te)	I Route Number,
	urs af	S	26						
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the best of my know liner: On the basis of examinat	wledge, death occurre tion and/or investigation	d at the time, date and place on, in my opinion, death occu	, and due to the cause rred at the time, date a	s) and manner as sind place, and due to	tated. the cause(s)
	thin 2 thin 2 the mple	Med	29b. Signature and title of certifier	and manner stated.	2	9c. License number	294 0	ate signed (Month,	Day Vaari
	F 3 F 8		1 10	1 60		D 48098	1	4/17/07	y, · · · · · · /
7		-	30. Name and address of person who o	completed cause of death /free	23a) /Tuna Print)	3-13016		T1110/	
	2	ĺ	Vijay Karumbunat		Hall Highw	ay, Crisfiel	d. MD 218	1 7	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat		ay, CIISIIEI	u, FID 210.	L /	
3	Registr		APR 1 9 2	2007	4 1	40			

			1 - For State Registrar	State of	Marylan		artmen			ind Mer	ntal Hygiei Reg.	40	07	14341
	Physic	ian	1. Decedent's Name (First, Middle,	Last)							Date of Death Month	Day	Year	3. Time of Death
	/Medi		James Irwin							A	pril 1	3 2	2007	03:02 AM
è	Examir	ner	4a. Facility Name (If not institution,				4b. City,	Town, or	Location of	f Death		4c. County	of Death	
			Union Hospital 5. Social Security Number 6		County Age (In yrs.	last hidhday)	If Under	1kto	n If Under 2	P4 Hrs o	Date of Birth	Ceci		des (Chara et French
	Funeral Director		136-18-4020	XXM 2□ F		Yrs.	Months	Days	Hours	Min.	(Month, Day, Ye			place (State or Foreign ntry)
			Usuat Residence of Decedent		86_		II				ept. 27,	1920	New	Jersey
	nylen how	_	10a. State 10b. County		10c. City	y, Town or Lo	ocation							10d. fnside City Limits
	Ba-f e	cto	Maryland Ceci	1	E	lkton								1 X Yes 2 ☐ No
	vith th	Die	10e. Street and Number				10f. Zip	Code			10g.	Citizen of V	What Cou	ntry?
	hours after death with the Marylend tural', or Items 23a or 28a-f ehow at Examiner must be notified at	by Funeral Director	150 East Main					2192				ited		
	Item Item	5	11. Marital Status 1 □ Never Married 2 ☒ Married	12. Was Decede	262	1	Was Deced If Yes, spec	ent of His ify Cubar	spanic Origi n, Mexican,	in? (Specify Puerto Rica	Yes or No- an, etc.)		ck, White,	can Indian, etc.
936	ors af		3 ☐ Widowed 4 ☐ Divorced	1 NYes 2 ff Yes, Give Year or Date	□ " Arn s: 1030_	ny -4.4	1□Yes 2	No X	Specify:			Specify	v: Wh:	ite
21215-0036	72 hours after death with the Maryler "natural", or Items 23a or 28e-f ehow idical Examinar must be notified at	Completed	15. Decedent's	Education	1939-	16a. Dece	dent's Usua	I Occupa	tion		16b	. Kind of Bu	usiness/In	dustry
21		ple	(Specify only highest Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	kind of wor DO NOT us	k aone ai e retired)	uring most (of working				
	ed wi	5 5	12			Pho	otogra	pher	-			News	pape	r
Ind	12 should be filed within hand Mental Hygiene. 7 ie marked other than "traumatic event, the Market	Be	17. Father's Name (First, Middle, La						18. Mother	's Name (Fi	rst, Middle, Maid	en Suman	7 e)	
<u>Y</u>	Men Men Marke Marke	2	George Vincent		l					aret E				
Maryland	s 1 and 2 should be filed within f Heelih and Mental Hygiene. Item 27 ie marked other than other traumatic event, Ita M		19a. Informant's Name/Relationship Leonard T. Cheese								oute Number, Cit			
_	s 1 and 2 of Heelth item 27 i		20a. Method of Disposition	eman / 501	20b. P	lace of Dispo	sition (Nam	e of	1	Date	kton, M	Location -		21921
Baltimore	ages nt of t: If it		1 ☐ Buriaf 2 🔯 Cremation 3		ite C	emetery, crer	natory or ot	her place		April		Location	City of To	JWII, State
Ē	permit. Pages Department of Important: If is any Injury or once.		4 □Donation 15 □ Other (Spe 21. Signature of Funeral Service Lig		Maye	erdale	Crema . Name and			15, 20		wark,		aware
Ba	permit. Departitingort		7-5	(1)	I					OLOU	ch Fune:			1 . 1 0100
			23a. Part1. Enter the disease, or	mplications that cau	sed the death							East	, mai	ryland 2190 Approximate
	Physician	2. 3	fmmediate Cause (Final	ty one cause on eac	h line	0 /	Dura	00 1	hat	50.			1	Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	a	as a consequ	tence of:	> X CN(en	JOG.	100	٠		- 13	LINKHOWN
	Examiner				DNOG	esti	p /	100	et e	lail	ue			unknown
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	ence of):	0 -	-00	7	7				W/12/100011
	cuted nd ransi	Examine	triat initiated events	c C	000	nan	1 a	rte	224	de	bea so			unknown
oʻ	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or	as a consequ	Jence of):								14.2.14.2.20
8760,	the the	lica		d		A								unknown
9	The law requires that the death certific is that been signed by the attending pogge 2 should be detached for use as	Physician/Medical	IF FEMALE:	"										
Вох	ath cattend	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetaf	death 3	Ectopic pre					23d. Dat Mor	te of delive	ary Day Year
	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnan 9□ Unknow	tat time of de	eath 5∟	Other (spe	ecify)						
P.O.	res thet the de signed by the a I be detached f		Part If. Other significant conditions	contributing to deat	h but not resu	ulting in the ur	nderlying ca	use giver	in Part I		23e. Did tobacc	use contr	ribute to th	ne cause of death?
ds	ures sign Id be	d by	Cum	entensis	na		,	3			1 🗆 Yes		3 Prob	
00	v requir been s should	Completed	10	00 0000	ton't	(0.								
Re	The law ite has sege 2 s	E D		milia	1 01) >	70070					24a. Was an autopsy performed?	240. V	vere auto prior to cor death?	psy findings available nptetion of cause of
a			25. Was case referred to medical								1□ Yes ZX	No 1	Yes	2V No
of Vital Records,	Attending Physician: The in death. ector: After this certificate hiby the funeral director, pege by the funeral director, pege	To Be	examiner?	Hospital:	ationt 2 1	ER/Outpatien	t 3 DO	Other			neck only one)		/=	
ō	g Phy er this		27. Manner of Death	28a. Date of I	njury	28b. Time of		C. Injury a	4 🗆 Nurs		5 Residence Describe how in			1)
ion	nding Fath. r: After e funer	atio	Natural 5 Pending 2 Accident investigat		Day Year)	Injury	М		es 2∐No	0				
Division	I or Attendi after death. Director: A i in by the fu	tific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 288. Place of	Injury - At hor	me, farm, stre	et, factory,	office		28f.	Location (Street City or Town, Sta	and Numbe	er or Rura	l Route Number,
Ö	tal or	Certification:		ballouing,	etc. (Specify)	,					City of Town, Sta	1(0)		
	lospi t hour uner uner	edicai	29a. Certifier 1 ☐ Certifying ((Check only 2 ☐ Medical Ex.	Physicien: To the be aminer: On the basis	st of my know	wledge, death	occurred a	t the time	, date and	place, and	due to the cause	(s) and ma	nner as st	ated.
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medi	/	and manner	stated.					. 50001100 d				
	S S S S		29b. Signature and title of certifier	,	MO		29c.	License		200		ate signed	(Moith,	Day, Year)
								0		372		-111	310	/ '
,	Tot I VA		180. Name and address of person wh	o completed cause of	death (Item	23a) (Type)	Print)	201	82	000	611	has	AAC	21921,
٦	Sta	te		(1)	strar's Signat	ure	- N		010	213	SECK	INN	10(1	10/10/1
	Registr		31. Date filed (Month Pay Year) APR 1 9	2007	eur ,	IS B	DE VEL	•						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar #8 per FH/wichd/4-20-07/dls Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** 2007 6 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Salisbury Hicomico REGIONAL Center Medical ININSULA 8. Date of Birth2-5-19349. Birthplace (State or Foreign (Month, Day, Year)

FEB. 13.1931 Mary Daylo If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) Social Security Number **Funeral** Days Min. 1 □ M 2 XF Hours 2 Director Usual Residence of Deceden filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10a. State 10b. County 1 ☐ Yes 2 No Director d Comico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21822 USA "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 📉 No Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Media. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaking Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barkley-Majette (daughter) 3885 St. Lid of Disposition (Name of cometery, crematory or other place) Salisbury, md 21801 Baltimore, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Friendshipumc Cemetery: 04

2. Name and Address of Ficility

Bennie Smith ALIEN, Maryland 04-21-07 4 Donation 5 □ Other (Specify) Isabella 21. Signature of Fund Salisbury 21801 FUNEVAL Home imd 23a. Part1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each term of the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine that the death certificate be executed burial-transi and Due to (or as a consequence of Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months! 4□Pregnant at time of death 9□Unknown Month Year 1 ☐ Yes 2 ☐ NO Division or Vital Records, P.O. the detached 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 1 Yes 2 No 3 Probably 4 1 Inknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 autopsy performed After this certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 N 2 ER/Outpatient 3 DOA 1 🗌 Yes 1 Dimpatient 2 28a. Date of Injury (Month, Day Year) 27. Manner Death 1 1 atural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) MD) Juluis D. Zant e of death (Item 23a) (Type, Print) 30. Name a Show! 540 32. Registrar's Signature 31. Date led (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

ORIGINAL

07-02563 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Carol Compton 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ April 4, 2007 0329 hrs Medical Examiner Carol Frances Compton 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Salisbury Wicomico Peninsula Regional Medical Center 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Director 577-96-1925 45 05/26/1961 Washington, DC M 2 X F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a. State 1 Yes 2 No items 23a or 28a-f show Maryland Wicomico Salisbury permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21801 USA 29180 Naylor Mill Road Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Never Married 2 X Married 2 X No Yes If Yes, Give Year 1 Yes 2 X No specify: Specify: white Widowed 4 Divorced 3 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) If item 27 is marked other than the Medical Health Care Registered Nurse 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Frances Gill traumatic event, Richard Raoul Bockover 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 CA 95521 3500 McMillan Ct., Arcata, Mary Irene Bockover/sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Itimore, crematory or other place) Burial 2 X Cremation 3 Removal from State 4/12/07 Important: Salisbury, MD Salisbury Crematory Donation 5 Other Specify: 22 Name and Address of Facility Signature of Funeral Service Licensee Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

| Association | Fune Professional | Association | Fune Professional | Association | Fune Professional | Association | Fune Professional | Association | Fune Professional | Association | Fune Professional | Association | Fune Professional | Association | Fune Professional | Association | Fune Professional | Association | Fune Professional | Association | Fune Professional | Association | Fune Professional | Association | Fune Professional | Association | Fune Professional | Association | Fune Professional | Association | Fune Professional | Fune Professional | Association | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Professional | Fune Profes 뗾 Physician Between Onset and failure. List only one cause on each line /Medical Death Alcohol and Mixed Drug (Olanzapine, Sertraline) Intoxication Immediate Cause (Final disease а 'xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Physician/Medical AMENDED UNPENDED the attending physician ed for use as the burial Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 V Unknown Completed of Vital Records, After this certificate has been stuneral director, page 2 should 24b. Were autopsy findings available 24a. Was an autonsy prior to completion of cause of death? performed ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medica Be examiner? Other₄ Hospital: 1 DOA Nursing Home 5 Residence 6 Inpatient 2 Y ER/Outpatient 3 Other: 1 ✓ Yes 28a. Date of Injury FOUND: 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work 27. Manner of Death Certification: FOUND: Natural Division Pending 1 Yes 2 ✔ No To the Funeral Director: completely filled in by the Apr 4, 2007 0249 hrs 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 29180 Naylor Mill Road, Salisbury, MD determined (Specify) Single Family Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 4, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 31. Date filed (Month Diay, Year) gistrar's Signature State 200 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Christian Robert 0425 04 16 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Coastal Hospice at the Lake Wicomico Salisbury if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 2 □ F 145-16-7667 Yrs. 84 12/28/1922 Pennsylvania Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30565 Bennett Road 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Tyes 2 No If Yes, Give Year or Dates: Navy 1 ☐ Yes 2 ☐ No Specify: white Specify. 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stock Company Statistician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James J. Christian Rosella Brady 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hollie C. Mitchell/daughter 30565 Bennett Rd., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 4/18/07 Salisbury, MD 21. Signature of Funeral Service Lice Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Call 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Encepholopath disease or condition resulting in death) Due to (or as a consequence of): Cont Sequentially list conditions, in a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 1☐Live birth 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) _ 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 2 No 1☐ Yes 1 ☐ Yes 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

The law requires that the death certificate be executed physician and the burial-transit Division or Vital Records, P.O. Box 68760. ast nse ō signed by the a page 2 s certificate Hospital or Attending Physician: director. hin 24 hours after death.

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes No 28a. Date of Injury (Month, Day Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D26278 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cantal Hospine

To the within 2 To the

Registrar

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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	oy Fur	1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		if Yes, sp 1 □ Yes	77	Specify:		Hican, etc.)		Black, Whi	
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		1	For State of Maryland / Department of Health and Me State Of Maryland / Department of Health and Me Certificate of Death	Reg.	0 0 0 12	14346
N			1. Decedent's Name (First, Middle, Last)		Day Year	3. Time of Death
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•	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death FREDERICK MEMORIAL HOSPITAL FREDERICK		FREDERIC	Κ
, (i)	Funeral Director			B. Date of Birth (Month, Day, Ye	9. Birth Con	nplace (State or Foreign untry)
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	h with the 23a or 28 st be not	al Director	10e. Street and Number 501 Prospect BLVD 2D ADT 3 21701		USA 14. Race - Ame	
200	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural" or items 23a or 28a-f show if item 27 is marked other than "natural" or items 22a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married If Yes, Specify Cuban, Mexican, Puerto Rill Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Specify Cuban, Mexican, Puerto Rill Yes, Specify Cuban, Mexican, Puerto Rill Yes, Specify:		Black, White	e, etc. ACK
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	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIBTE A KAMI, My 814 Toll House House APR 2 0 2007 APR 2 0 2007 Signature	NEDER	icic Mr	2170
	S Regis	State strar	31. Date filed (Month, Day, Year) APR 2 0 2007			

Baltimore, Maryland 21215-0036

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Š		3 ☐ Widowed			If Yes, G Year or I	2 □ No live Dates: 1 Q	66-196	69	1 ☐ Yes 2 🔀	No S	pecify:				Specif	y: WH	ITE	
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Be	17	. Father's Name	(First, Middle,	Last)						18.	. Mother's	Name	(First, Middle	e, Maide	n Surnar	пө)		
2		FRANKLIN	DUNCA	N						_ A	GNES	BE	CK					
	1	9a. Informant's N	lame/Relations	hip (Type	e. Print)			19b. Maili	ng Address (St	reet and	Number o	r Rura	al Route Numb	ber, City	or Town,	, State, 2	Zip Code	e)
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	20	a. Method of Dis	•	0 DD-		- 64-4-	20b. Plac	ce of Dispo	osition (Name o	of rplace)			Date TT 10	20c. L	ocation -	- City or	Town, S	State
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Division or Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)

APR 18 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Curft's (Tarris, M) 900 Best 50fr Rd Ste 300 Annapolis M0 2140

31. Date filed (Month, Day, Year)

ADD 19 2003

Dhusia		1- State Registrar		Cei	rtificate of D	eath	F	Reg. No.		
		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month	ath Day	Yeer	3. Time of Death
Physic /Medi		Gussie	Louise E	Elliott				16, 200	7	1:55 P
Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. Count	y of Death	
		27479 Walnut Tre	e Road		Salisbu	ry		Wic	omico	
Funeral		5. Social Security Number 6. Se	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h v, Year)	9. Birthp	place (State or Foreigntry)
Director		214-10-7856	^{□ M 2} 1 95	Yrs.			3/11/19	912	Ten	nessee
pu »		Usual Residence of Decedent 10a, State 10b, County	100	c. City, Town or Lo	ncation				1	0d. Inside City Limit
anyla ehov	_	Toa. State Tob. County	100							1 ☐ Yes 2 ₩N
Se-f	Director	Maryland Wicomic	0	Salisbur						
ith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
23a		27479 Walnut Tr			21801			USA		
be filed within 72 hours after death with the Maryland Ital Hyglene. Id other than "natural", or Iteme 23a or 28e-f ehow event, the Medical Examinar must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	- 14. Ra Bla	ce - Americ ick, White,	
afte or i		1 Never Married 2 Married	1 ∐Yes 2 🙀 No If Yes, Give		1⊡Yes 2 ∑ No	Specify:		Speci	y: wh	ite
ural',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:					10 10 10		1
filed within 72 h Hygiene other than "natuent, the Medica	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occupa kind of work done do DO NOT use retired)	uring most of work	ing	16b. Kind of E	susiness/in	dustry
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lygie her t	ပိ	17. Father's Name (First, Middle, Last)		Sean	stress	18. Mother's Name	o /First Middle			acturing
be fi	Be	_	t- t						1110/	
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2 should and term		19a. Informant's Name/Relationship (7			ng Address <i>(Street al</i> 1 Bakerton					
s 1 and 2 should f Health and Men item 27 is marke other treumatic		William H. Elliot								
of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	D	20b. Place of Dispo cemetery, crei	matory or other place)	Date	20c. Location	·	
Pag nent ant: I	1	4 ☐ Donation 5 ☐ Other (Specify	, i	Wicomico Park	Memorial	4/2	1/07	Salis	bury,	MD
permit. Pages to Department of Himportant: If ite eny injury or ot once.		21 Signature of Funeral Service Licen	see	22	2. Name and Address Holloway	s of Facility	Home Pro	ofessio	nal A	ssociatio
8 9 = 8		David At. (Brom	YPOON CES	SP	501 Snow	Hill Rd.	Salisk	oury, M	D 218	04
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the	death. Do not en	ter the mode of dying	, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
Dhysisian		Immediate Cause (Final		41		C				Onset and Death
Physician /Medical		disease or condition resulting in death)		META	STATIC	/3427-C	7 7			
Examiner			Due to (or as a co	insequence of):		J. 0(1)			-	
			Due to (or as a co	onsequence of);		3,0(1	1			
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31. Date filed (Month, Day, Year) State Registrar



Physician /Medical **Examiner**

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentalle Hyglene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show minportant: If them 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

/Medical

Immediate Cause (Final disease or condition resulting in death) Massive **Physician** Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₹ Completed the Hospital or Attending Physician; hin 24 hours atter death. the Funeral Director; After this certified 25. Was case referred to medical examiner? Be Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 SER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical and manner stated. 29c. License number OBAFEMI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Opesanmi, M.D. 7503 Surratts Rd., Clinton, MD Obafemi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 9 2007 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 09^{Day} April 2007 ear Featherson James David 14:21 p M 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Clinton Southern Maryland Hospital Months Days Hours Min. Min. March 24,1935 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1**X** M 2 □ F North Carolina 243-50-3028 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director MD Waldorf 1X Yes 2 No Charles 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5133 B. Shawe P1. 20602 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contract Specialist Governemnt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Winstead Madie Featherson Eugene 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5133 B. Shawe Pl., Waldorf, MD Dorothy Featherson/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem; 4/16/2007 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy St. NW, Washington, DC 23a. Part1. Enter the disease, or complications to care ed the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physicia Medical Examir		1. Decedent's Name (First, Middle		l c				2. Date of Death Month April 14, 20		3 Time of Death 1932 hrs
1%		Jarrod Amahd 4 4a. Facility Name (if not institution	n, give street and number	t)			cation of Death		4c. County of Deat	
Funeral		PG Hospital Center 5. Social Security Number	6. Sex 7. As	qe (In yrs.		everly Inder 1 Year	If Under 24Hrs	s. 8. Date of Birt	Prince Georg	
Director		579-98-4639	1XXM 2 F	31	14-	nths Days	Hours Mir	09/06	/1975 Forei	intwissiffington ountry) DC
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death wit or items?	Funeral	11. Marital Status 1 XX Never Married 2 Ma	1 Yes 2		If Yes, spe	ecify Cuban, M	Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
urs after tural",	화	3 Widowed 4 Divo	orced If Yes, Give Year or Dates: cify only highest grade co	ompleted)	16a. Decedent's Usu		Give kind of		Specify: B 16b. Kind of Business	lack /Industry
136 hin 72 hore.e. than "na edical Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or		during most of v	working life. Di ck Cler		ired)	Pvt	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Nental Hygiene. Important: If item 27 is marked other than injury or other transmatic event, the Medica	Be Com	17. Father's Name (First, Middle, Henry Muse					.Mother's Name	e (First, Middle, M	faiden Surname)	
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To t To t	Medical	29b. Signature and title of certifier	and manner stated			29c. License n			29d. Date signed (Mo	
2		Calific	AT.	2.		O.C.M.	E.		April 15, 2007	
		30. Name and address of person Zabiullah Ali, M.D.	who completed cause of Assistant Medical E			eet, Baltim	ore, MD 21	201		
St: Regist	ate	31. Date filed (MAYD, 19ay, Year)	2007 32. Régistra	rar's Signati	1. Specie	,				

		1	For State Registrar	State of Maryland		artment of			ital Hygie Reg.	/ 1111	7 14351
變	Physicia	an	1. Decedent's Name (First, Middle, Last	V. FEAST	ER				Date of Death Month APPLL	2	3. Time of Death ear 5.40 AM
	/Medic Examin	30	a. Facility Name (If not institution, give	street and number)		4b. City, Town	or Location of	of Death MARYLAND	X621771	4c. County of	Death DERICK
4	Funeral Director		5. Social Security Number 6. Se 214-28-5971	x 7. Age (<i>In yrs. I</i>	ast birthday) Yrs.	If Under 1 Yea Months Day		24 Hrs. 8. [Min. F]	Date of Birth (Month, Day, Ye EB 19 1	920 F	Birthplace (State or Foreign Country) rederick, MD
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	with the h te or 28a-1 t be notiff	Funeral Director	10e. Street and Number 804 Knoxville Roa			10f. Zip Code	1758		10g.	. Citizen of Wh.	at Country?
36	d within 72 hours after death with the Maryland jiene. I than "natural", or itema 23a or 28a-f ehow I'ne Madical Examinant te notiliad al	by Funera	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ③ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 [] Yes 2 [X]No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Co	iban, Mexicai	n, Puerto Hica	Yes or No- an, etc.)	Black,	American Indian, White, etc. White
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land 2	should be filed nd Mental Hygid marked other imatic event, II	To Be C	17. Father's Name (First, Middle, Last) Albert S. Linck					ers Name <i>(Fi</i> ly Wic	irst, Middle, Ma. kless	iden Sumame)	
Ž	and 2 11th au 27 ia	18	19a. Informant's Name/Relationship (7) JoAnna Henson, Da	_		ng Address (Stre					ate, Zip Code) 21722
Baltimore,	Pages 1 an nent of Heal int: if Item 2 iry or other		20a. Method of Disposition 1 Burial 2 Toremation 3 4 Donalish 5 Other (Specify	Removal from State	emetery, cre	osition (Name of matory or other p wn Crema		Date 4/19/0		c. Location · Ci	wn, MD
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8760,	Physician physician and physic	icai Examiner	23a. Part1. Enter the disease, or composition of the part of the p	b. Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq d.	uence of):	ELL L					Interval Between Onset and Death
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of	Jing Ph I. After th funeral	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. I	4 N njury at Work?	280	5 Residen		(Openin) ROUSE
Division	tal or Atte s efter de ai Directo ed in by th	Certification	3 Suicide 6 Could not be determined	building, etc. (Special	fy)				City or Town,	State)	r or Rural Route Number,
	To the Hospital or Attent within 24 hours effer death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examone)	ysician: To the best of my kind niner: On the basis of examina and manner stated.	cwladge, dat ation and/or i	nvestigation, in n	ny opinion, de	eath occurred	at the time, dat	e and place, ar	nd due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	MD			ense number 56314			3	(Month, Day, Year) TH 2007
	5		30. Name and oddress of person who		THORA	Print)		(
	St Regist	ate rar	24 Date filed (Month Day Year)	2007 32. egistrar's Sign	atuly A	porti					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Clifford Leslie Foreacre, Sr. April 18 2007 09:50 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 217 East Cecil Avenue North East Ceci1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1**X** M 2□ F Yrs 220-22-5155 79 June 22, 1927 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XXYes 2 No Director Maryland| Ceci1 North East 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 217 East Cecil Avenue 21901 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X) Yes 2 No US Army If Yes, Give Year or Dates: 1945-87 1 Never Married 2XXMarried 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Warehouse Supervisor Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Leslie Foreacre Lola Viola Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna M. Foreacre / Wife 217 East Cecil Avenue, North East, Maryland 21901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21, 2007 Mary Anne's Cem. North East, Maryland 21. Signature uneral Service Livense 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION Hours Due to (or as a consequence of): COLONALY ALTERY DISEASE YEARS Sequentially list conditions, if any, leading to instructions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of HYPERTENSION Due to (or as a consequence of) HYPERLIPIDEMIA IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Year 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed 2 No 1∐ Yes 25. Was case referred to medical examiner? 26 Place of Death (Check only one Н 1 Yes 2 No her (Specify)

death certificate be executed physician and s the burial-trans as signed by t d be detach has or Attending To the Hosping, within 24 hours after death.

To the Funeral Director; Aft

Box 68760.

P.0.

Division or Vital Records,

Physician

/Medical

Examiner

Funeral

Director

of Mental Hygiene.

marked other than "natural", or items 23a or 28a-f show
more event, the Medical Examiner must be notified at

traumatic event, the

Jubould be filt.

permit. Pages 1 and 2.
Department of Health at Important: If Item 27 is any Injury or other trau.

Physician

Examiner

/Medical

Pages 1

filed within 72 hours after death

3altimore, Maryland 21215-0036

Examiner Physician/Medical ş Completed Be ² Certification:

Medica

					- Land	o. I lace of Dea		reck offig offe)	
ospital: 1 ☐ Inpatient			3 🗆 [OOA	Other:	4 ☐ Nursing H	lome	5 Residence	6 □Oth
28a. Date of Injury (Month. Day Ye.	ar)	28b. Time of		28c.	Injury at		28d.	Describe how inju	игу оссиг

1 Natural 5 Pending Μ investigation 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

rred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

> 29c. License number DOOYTTU

29d. Date signed (Month, Day, Year) April 19, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Switz #3 ELKTUN MARYLAND GAL-EL 304-306 NOOSL Street

Registrar

31. Date filed (Month, Day, Year) 2007

29b. Signature and title of certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend item 1- State Registrar #8 per FH/wichd/4-19-07/dls Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Freeman Norma Lee 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hoomic ENINSULA 30/136400 Kegi onal If Under 1 Year | If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, 8-29 Year) -25 9. Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🕱 F 218-16-7997 81 Director 5/21/1925 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 Yes 2 No Director Mardela Springs Maryland Wicomico 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21837 25063 Delmar Road USA natural", or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 □ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify à white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Item 27 is marked other thar 11 Teachers Assistant Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Aquilla H. Evans Alice Graham ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Freeman/husband 25063 Delmar Rd., Mardela Springs, MD 21837 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mardela Memorial Date Pages 1 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery
22. Name and Address of Facility 4/19/07 Mardela Springs, MD 21. Signature of Funeral S. Vice Licenses Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MULTIRE SYSTEM ORGAN FAMILE disease or condition resulting in death) DAYS /Medical Due to (or as a consequence of): Examiner ZWEEKS REPLACEMENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MITTOLAL VANE Due to (or as a consequence or): Examine be executed YEMS MARINE VANGE LEAY and burial-tra Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending IF FEMALE use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy 2 No 1☐ Yes Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**□/**No Hospital: 1 TYes 1 Inpatient 2 ER/Outpatient 3□ DOA ٩ this funeral 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò Hospital 29a. Certifier 1 Yertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

Dr. Jeffrey Wieland 31. Date filed (Month, Day, Year)

APR 1 8 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 E. Carroll St., Salisbury, MD 21801 32. Registrar's Signature

D34768

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of M	iaryiari			of Death	and Ment		eg. No:-	07	The second	354
	Physici	an	1. Decedent's Name (First, Middle, La.	st)					M	ite of Dear	Day	Year		e of Death
A REPORT	/Medio	cal	Joseph Green 4a. Facility Name (If not institution, giv	e street and number	r)			4b. City. To	Ap1		14, 20 4c. County		10:	25 pm
J	Examir	ner	Saint Thomas Moo			nter			tsville		Princ		orge	's
Г	Funeral Director		Social Security Number 6. S			last birthday) Yrs.	If Under 1 You Months Da	ear If Under		te of Birth onth, Day -18-1		9. Birthp		te or Foreign
	put *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	v. Town or Lo	ocation					1	Od. Inside	e City Limits
	Maryla f sho	힏	D.C.			Was	shingto	n						res 2□No
	or 28s	Je C	10e. Street and Number				10f. Zip Coo	de		1	0g. Citizen of V		ntry?	
	ath wi	rai	2801 14th Street					20009			U.S.A			
020	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ha Mcdical Examina must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 X Yes 2 ☐ If Yes, Give Year or Dates:	? 10944			of Hispanic Original Cuban, Mexican No Specify:	gin? (Specify Y i, Puerto Rican	es or No- etc.)	Віас	e - Americk, White,	etc.	le comment
2-0	72 ho natur dical	eted	15. Decedent's Ec	lucation de completed)		(Give	dent's Usual Ockind of work do	one durina mosi	t of working		16b. Kind of Bu	usiness/In	dustry	
121	1 within 72 ho liene. r than *natur the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOTuse re orer	etired)			Constr	ucti	on	
102	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last)		-			18. Mothe	er's Name (Firs	, Middle,	Maiden Sumam	10)		
/lar	• • •	To B	Carey Samuel					Ha	11ie Gr	een				
Baltimore, Maryland 21215-0020	2 0 7 8		19a. Informant's Name/Relationship (Joseph P. Gree			19b. Maili 420. (ng Address <i>(St.</i> Girard	reet and Number Street g, Mary	#202	te Number	r, City or Town,	State, Zip	Code)	
ē,	Healt Healt Hem 2		20a. Method of Disposition	, 5011	20b. F	Galt Place of Dispo	nersbur osition (Name of matory or other	g, Mary	Dat		20c. Location -	City or To	wn, State	9
E O	Pages 1 end ment of Healtl ant: if item 27 lury or other 1		1 A Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification)				Memoria		4/2	1/07	Landov	ær,	Mary	land
Salti	permit. Pages Department of Important: If if any injury or one		21. Signature of Funeral Service Licer	isee >	-1			ddress of Facilit						
ш	205 20		Manda C.	Dacon C	C 3	41		th Stre				n, D		
>	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each	line.	dere	ote C	lardic				250	Onset a	mate Between nd Death
		ner			Due to (c	or as a conse	quence of):						1	
oʻ	tificate be executed g physician and es the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	Due to (c	r as a conse	quence of):					1		
68760,	cete be physici the bu	edicai	that initiated events	C	Due to (o	r as a consec	quence of):							
			L	d										
Box	death e atter	Physician/M	Part II. Other algnificant conditions o	ontributing to death	but not res	ulting in the u	nderlying cause	e given in Part I.	. 2	3b. Did to	obacco usa con	ntribute te	tha cau	se of death?
P.O.	thet the death cert led by the attendin deteched for use	Phy	Chroniz ne	nal 7	uilo	Re				1 🗆 Y	as 2□'No	3 Pro	bably 4	Unknown
Division of Vital Records,	law requires thet the death cer nas been signed by the attendir s 2 should be deteched for use	Completed by	Panchen				Ates	Mello	tus 2	4a. Was a	in autopsy med?	av	ailable pri mpletion	sy findings ior to of cause
Be	o	ошр								1 □ Y	es and No		déath? ⊒Yes :	2□ No
ital	ysician: The is certificate director, pag	BeC	25. Was case referred to medical examiner?					26. Place	of Death (Che	ck only or	1e)	/		
)t	S 0 5	ို	1 ☐ Yes 2 【No	Hospital: 1 ☐ Inpat		ER/Outpatie			1		ence 6 □Oth		y)	
ono	After fune	tion:	27. Manner of Death 13 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inj (Month, D	ay Year)	28b. Time o Injury		Injury at Work? 1 ☐ Yes 2 ☐ I		escribe n	ow injury occur	red		
Divisi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Ir	njury - At ho etc. <i>(Specif</i>	ome, farm, st	reet, factory, of	fice		ocation (S ity or Tow	treet and Numb n, State)	er or Rura	I Route A	Vumber,
	t Hospital 24 hours a Funarai i etely filled	edicai (29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best ninar: On the basis and manner s	of examina	wledge, deat tion and/or in	h occurred at th vestigation, in r	ne time, date an my opinion, dea	d place, and du th occurred at t	e to the c he time, d	ause(s) and ma late and place,	nner as s and due to	tated.	se(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier					cense number			9d. Date signe			
	->-0		Mund	lend	0	neh	ul i	1018	52		IT AP	RIL	200	7
2	(2)		30 Name and address of person who	ODFM	death (Iten	n 23a) (Type,	Print) URENS	1018 56 wy 18	Palty	att	50:14 C	W	25	747
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	ture		,						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

29d. Date signed (Month, Day, Year)

CHEVERY MD 20185

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

GARY

(Check only

one)



30. Name and address of person who/completed cause of death (Item 23a) (Type, Print)

D58951

within 24

To the F

Physician /Medical Examiner

ed by the attending physician and detached for use as the burial-tran

signed by t

director, page 2 should

funeral

completely

Certification: To Be

Medical

this certificate has

I or Attending Physician: after death. Director: After this certifice

To the Hospital within 24 hours a To the Funeral I

as the

Division or Vital Records, P.O. Box 68760,

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

filed within 72 hours after Hygiene.

Hygiene.

Ther than "natural" or ite

s 1 and 2 should be filed wi f Health and Mental Hygien Item 27 is marked other th

Baltimore, Maryland 21215-0036

autopsy performed? Yes 2 1 No 1☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner' 2 No 1 Yes 27. Manner of Death 1 Natural

5 Pending investigation 6 Could not be

determined

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA 28b. Time of Injury

28c. Injury at Work? 1 Yes 2 No

26. Place of Death (Check only one)

Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

2 ☐ Accident

3 ☐ Suicide

4 THomicide

EXEcrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 14156 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ciro A. Montanez MD 1300 Mercantile Lane #140 Largo, Maryland 20774

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year) APR-1 9 2007

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

ORIGINAL

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** GRIFFIN ERNEST 2007 4:50 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Charles Charles County Nursing & Rehab LaPlata If Under 1 Year If Under 24 Hrs. Months Days Hours Min (Month, Day, Year)
Oct. 13,1911 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 3M 2 □ F 95 214-32-9870 Virginia Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or iteme 23s or 28e-f show traumatic event, the Medical Examinar must be notified at Director 1 X Yes 2 ☐ No Maryland Charles Indian Head 10e. Street and Number 10g. Citizen of What Country? 34 Elder Place U.S.a. 20640 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 Yes 2 No If Yes, Give X Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiane. Brakeman U.S. Government 12 permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked othe eny injury or other traumatic event, size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alice Lovelass Henry Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34 Elder Place, Indian Head, Md. 20640 Wife Leona B. Griffin Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Trinity Memorial Gardens 19, 2007 4 ☐ Donation 5 ☐ Other (Specify) Waldorf, Maryland 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately approximatel Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OCCIPHA parietotempural Physician WEEKS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physiclen and s the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 PREUMONIA, MIIMALY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 212 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 2√ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Division Injury 1 Natural 5 Pending death. 1 Tes 2 No investigation 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 \(\text{Homicide} \) efter pellif 24 hours (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. within 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) SINDLEUM APril 16/2007 D0061616 R. SINDHWAN (Waldorf, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square 11350 Pembrooke 31. Date filed (Month, Day, Year) egistrar's Signat State **APR 1 9** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month -Physician 745 AM Margaret Greer 2007 4pril /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Manor lanokin Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months 1 ☐ M 2 🕱 F 219-03-0110 86 11/25/1920 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or 28a-f show treumatic event, the Madical Examiner must be notified at 1 Yes 2 No Maryland Director Somerset Princess anne 10g. Citizen of What Country? 10f, Zip Code 10e, Street and Number 27150 Oriole Road 21853 USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Affiled Folces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene, Important: if Item 27 is marked other than "natural", or it any injury or other treumattic event, the Medical Exemina 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Flementary/Secondary (0-12) College (1-4or 5+) Hardware Store 12 Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace W. La Munion William Bennett Barr ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 27146 Oriole Rd., Princess Anne, MD 21853 Bennett A. Greer/son 20b. Place of Disposition (Name of cometery, crematory or other place Wicomico Memorial Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4/20/07 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Park 22. Name and Address of Facility Holloway Funeral Home Profe 501 Snow Hill Rd. Salisbury 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fin. 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd. Salisbury, MD 21804 Approximate Intarval Batween On set and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to () as a consequence of): Examine that initiated events resulting in death) Last signed by the attending physician and the detached for use as the burial-tran as a consequence of) Medical Certification: To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Day Year Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manper of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 No investigation 2 Accident filled in by the 6 Could not be determined 3 🗆 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records, P.O. Box 68760 or Attending Physicien:

Mangaret

Baltimore, Maryland 21215-0036

within 24 hours after death. To the Funerel Director: A

State Registrar

Joseph KA F

4 Homicide

29b. Signature and title of certifier

29a. Certifier (Check only one)

> Po 15 burg 32. Pegistrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 1)20441 29d. Date signed (Month, Day, Year)

4-18-07

APR 1 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 7:40 P M Griffith Eleanor Virginia April 11 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BERLIN NURSING & REHABILITATION CENTER BERLIN WORCESTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🔀 F 216-54-2316 96 Director 11/22/1920 Washington, DC Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Berlin Director Maryland Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Meadow St. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗶 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Griffith, Eleanor Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: 3 ₩ Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Levy Leona Strauss 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gayle N. Peterson/daughter 10764 Waterberry Dr., Boca Raton, FL 33498 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/16/07 Salisbury Crematory Salisbury, MD 21. Signature of Funera 22. Name and Address of Facility
HOLloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Live birth in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be examiner? Other: 1 🗌 Yes 1 | Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funerail 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print 09 31. Date filed (Month, Day, 32. gistrar's Signature Year) State

Registrar

18

2007

			For State Registrar	State of Ma	aryland / E	epartme		alth and N	Mental Hyg	iene	1100
×	Physici		Registrar Decedent's Name (First, Middle, Harry	Last)	Hous		ile or be	Jan -	2. Date of Deat	eg. No. h h .3 ^{Day} 2007 ^{Year}	3. Time of Death 9:00 P M
)	/Medio Examin		4a. Facility Name (If not institution, the Heartland of Hya		ırsing H		y, Town, or Lo	ocation of Death	1	4c. County of Death Prince Geo	rge's
	Funeral Director		465-30-7355		e (In yrs. last birt 31	hday) If Und Month		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		ace (State or Foreign try) dy, TX
	e Maryland a-f show tifled at	ctor	Usual Residence of Decedent	George's	10c. City, Towr	or Location				10	0d. Inside City Limits 1 Yes 2 No
	th with the 23a or 28 ast be no	al Director	10e. Street and Number 6500 Riggs Road	1		10f. 2	Zip Code 20783			Og. Citizen of What Coun United Stat	
5-0036	be filed within 72 hours after death with the Maryland Hygiene. id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ₩ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 17 Yes 2 1 If Yes, Give Year or Dates:				anic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, e Specify: B1	
0-6121 2	filed within 72 ho Hygiene. other than "natur ent, the Medical I	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12th	Education grade completed) College (1-4or t		(Give kind of life. DO NOT	sual Occupation work done duri use retired) B Engin	ing most of wor	king	16b. Kind of Business/Ind Private	ustry
land	2 should be filed n and Mental Hyg is marked other raumatic event,	To Be C	17. Father's Name (First, Middle, La Lennie J. Hous	,				3. Mother's Nam Viola S	ne (First, Middle, M Shelton	Maiden Surname)	
, Maryland	and 2 shouath and Notestath and Notestath and Notestath and Notestath		19a. Informant's Name/Relationship		- 1	_	ss (Street and			City or Town, State, Zip	*
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item Z7 is marked any injury or other traumatic e once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Service)	ecify)	20b. Place of cemeter	incoln(Cremato	ory 4/18	/2007 B	ecc. Location - City or To Brentwood, M In Funeral H	D
ñ	Dep Imp		Suhard Tho	1250 II		3401				entwood, MD	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or d shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on each li Alzhein	the death. Do r ne. ner's di: a consequence o	sease	ode of dying, s	such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	cuted nd	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underhan Cause (Disease or injury that initiated events.	b	a consequence of	of):					
3760,	ate be executed hysician and the burial-transit	<u>8</u>	resulting in death) Last	Due to (or as	a consequence of	of):					
O. Box 68	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ∐Live birth 4 ∏Pregnant a 9 ∭Unknown	2 Fetal death	3⊟Ectopid 5 □ Other	pregnancy (specify)			23d. Date of delive Month	ry Day Year
ecords, P.	w requires that the debeen signed by the should be detached	þ	Part II. Other significant condition Hypertension	s contributing to death b	ut not resulting in	the underlying	g cause given i	in Part I.		oacco use contribute to the	
Ital Hecc	The faw ate has b page 2 sl	Completed							24a. Was ai autops perforn 1 Yes 2	y prior to con ned? death?	osy findings available inpletion of cause of
7	Physiclan: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	ACTER/O	matical OF	Other:		th (Check only on		
ion or	Ing Phy After this uneral d	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Inju	ent 2 ☐ ER/Ou iry 28b. 1 y Year)	tpatient 3 ime of njury M	28c. Injury at Work?			ence 6 Other (Specify ow injury occurred	·)
DIVISION	o the Hospital or Attendithin 24 hours after death. the Funeral Director: /	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed Zoe. Place of Inj	ury - At home, fa c. (Specify)	rm, street, fact	ory, office		28f. Location (St. City or Town	reet and Number or Rura a, State)	Route Number,
	the Hospithin 24 hours the Funera	Medical (f examination an					ause(s) and manner as st ate and place, and due to	
	i i i i	Ž	29b. Signature and title of certifier	0			29c. License ni	umber	2	9d. Date signed (Month, I	Day, Year)

To the within To the Comp

State Registrar

5711 Sarvis Ave. Suite 200 Riverdale, MD 20737 Suresh K. Muttah, MD 31. Date filed (Month, Day, Year)
APR-1 9 2007 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

D 0058290

4/17/2007

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 1 17°, 2007° **Physician** 4:30A. Lenard Holley /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Magnolia Center Lanham Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Oct. 2, 1934 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Funeral 1 M 2 □ F Illinois 326-28-9923 72 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a, Slate 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Maryland | Prince George's College Park Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 20740 9800 Cherry Hill Road United States Iteme 23a permit. Pages 1 and 2 should be filed within 72 hours effer death a Department of Heelih and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Iteme 23a any hijury or other traumatic event, The Medical Examinational ADES. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Xto If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phillip S. Holley Evelyn Kuhen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3438 S. Normal Avenue Chicago, Illinois 60616 Robert Holley -son 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metropolitan Crematory 4/18/2007 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Abdominal Lymphoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown cete hes been signed | pege 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Cirrhosis; Diabetes 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2X No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No After this certifice funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending within 24 hours after death.

To the Funerel Director: Af 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the e 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D26287 April 17, 2007 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael Berard, M.D. 7305 Baltimore Blvd., #107 College Park, Maryland 20740 31. Date liled (Month, Day, Year) 32 Registrar's Signature 19 2007 Registrar

			State of Maryland / Department	artment of Health and N rtificate of Death	fental Hygier	2001	14363
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici		Frances Harless		April 14.	2007 Year	4:30 A M
100	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
	Exami		Manor Care Chevy Chase	Chevy Chase		Montgome	W17
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth		thplace (State or Foreign ountry)
	Director		215-22-0262 1□M 2XF 83 Yrs.	Months Days Hours Min.	Jan. 22.		st Virginia
	pu ,		Usual Residence of Decedent				
	aryla	_	10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits
	8a-1	cto		on, D.C.			1 ▼ Yes 2 No
	or 2	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What C	ountry?
	within 72 hours after death with the Maryland ene. Then "natural", or Items 23s or 28s-f show the Marical Expedient court be notified at		1610 16th Street, N.W.	20009		U.S.A.	
	er de	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
36	'or	by F	1 X Never Married 2 Married 1	1 ☐ Yes 2 🛣 No Specify:		Specify:	
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212	iene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 1.2 Secondary (0-12) College (1-4or 5+)	cretary	C	lerical	
ğ	be filed within 72 hours after death with the Marylan ntal Hygione. Ide Hygione. Ide other than "natural", or Items 23a or 28a-1 show other than "natural", or Items 23a or 28a-1 show event, the MacKeal Expolprer cant be notified at	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	len Sumame)	
Maryland 21215-0036	should be nd Mental marked o	To B	Unknown	Unknov	m		
a _Z	should that and Ment se marked inmatic e	_	19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rur	al Route Number, Cit	y or Town, State,	Zip Code)
	elth a elth a 27 is		Robert A. Gazzola/Attorney 1400	K St., N.W. Suite	1010 Wash	DC 200	05
e,	es 1 and 2 should to the the the the the the the the the the		20a. Method of Disposition 20b. Place of Disposition	sition (Name of	Date 20c.	Location - City or	
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Baltimore,	permit. Pages 1 Depertment of H Importent: If Ite any injury or ot once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility De			, ,
ñ	88 E 5 8		James El III	22 Wisconsin Ave.	, N.W. Was	shington	DC 20007
			23a. Part Enter the disease, or complications that caused the death. Do not ent	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition a Metastatic Breast	Comment			Onset and Death
10	/Medical		resulting in death) a. <u>Hetastatic Breast</u> Due to (or as a consequence of):	. Cancer			
	Examiner		Sequentially list conditions b. Ischemic Cardiomy	opathy			
	D ==	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	acute ind trans	Examiner	that initiated events c. Congestive near t	Failure			
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8760	icate be executed physicien and s the burial-transit	dical	d. Hypertension				
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a.	ihat ti ad by detac	P.	Part II. Other significant conditions contributing to death but not resulting in the u	ndertving cause given in Part I	23e. Did tobacc	o use contribute t	o the cause of death?
ds,	signed to det	b 5	Chronic Obstructive Pulmonary Disease		1 ☐ Yes		robably 4∑Unknown
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ě	has has	mpi	bl2 deficiency, anemia		24a. Was an autopsy performed	24b. Were a pnor to death?	utopsy findings available completion of cause of
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Vital	sician: certific rector.	Be	25. Was case referred to medical examiner?	04	h (Check only one)		
ō	Phys this raldi	- To	1 ☐ Yes 2X No	1 3 DOA 4 X Nursing Ho	me 5 Residence		ecify)
0	ding f h. After funer	ti E	1 XNatural 5 Pending (Month, Day Year) Injury	28c. Injury at Work? M 1 Yes 2 No	20d. Describe now ii	ijury occurred	
<u>s</u>	Attendi or death. octor: A by the fu	fica	3 Suicide 6 Could not be 28e Place of Injury - At home farm str		28l. Location (Street	and Number or B	ural Route Number
Division of	of or Att efter d Direct d in by	Certification:	4 Homicide determined 259. Place of injury - At home, farm, str	, and a second	City or Town, St.		
	To the Hospitel or Attending Physician: within 24 hours selfer death "To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place,	and due to the cause	(s) and manner a	s stated.
	n 24 h	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occur	red at the time, date a	and place, and du	e to the cause(s)
4.	To the within 2 To the comple	Σ	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Mon	th, Day, Year)
1			Kuti Vohra M.D.	D-20274	Ap	ril 14,	2007
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			
			Kirti Vohra, M.D. 7710 Bradley Blvd.	Bethesda, Marylan	d 20817		
	Sta		APR 1 9 2007	and a			
	Registr	ar	WILL I'M TOOL WESTER TO THE				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 2 Tay 2007 6:50 A M Robert Lee Hull 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Ravenwood Lutheran Village Hagerstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) West Virginia Months 1⊠M 2□F 87 233-16-6903 June 6,1919 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1√TYes 2 No Maryland | Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1158 Cottage Court 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: ²□No 1944-1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. Specify: white 3 Widowed 4 Divorced 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) welder 12 civil service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zenna Duling Jess Ulysses Hu11 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Hull - wife 1158 Cottage Court, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition April 25, 2007 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Memorial Williamsport, Maryland 22. Name and A ress Facility Minnich Funeral Home 21. Signature of Funeral Service Licensee formes 415 East Wilson Blvd., Hagerstown, Maryland 21740 d. 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 vasallen disease shewou Iwek Due to (or as a consequence of): 2 marts weeward Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) a I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 1 Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No autopsy perform 1 Yes 2 2[**X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any liquiry or other traumatic event, the IM drai Examiner must be notified at once.

Baltimore, Maryland 21215-0036

physician and s the burial-trans attending properties for use as signed by the a s certificate has b irector, page 2 sl director, n 24 hours after death.

The Funeral Director: A pletely filled in by the

Examiner Medical Certification: To

Physician/Medical þ Be Completed

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

JH.5+1

To the Hosp within 24 hor To the Fune completely fi

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

5 Pending investigation

6 ☐ Could not be

State Registrar

29b. Signature and title of certifier

368 5 14AF1.

28a. Date of Injury (Month, Day Year)

and manner stated.

D28365

29c. License number

28c. Injury at Work?

1 Yes

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) null Slut- Hagerstown 1910 2/740

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

		1 - For State of Maryland / State of Maryland /	Department of Health and N Certificate of Death		ne No 0 0 7	14365
		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Physici /Medic	cal	AGNES MARIE HOUSE	(1) (2) Table 1 (2) (1)		20 2007	5:55 P M
Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	TON
Funeral		6038 ROHRERSVILLE ROAD 5. Social Security Number 6. Sex 7. Age (In yrs. last b		8. Date of Birth (Month, Day, Ye	WASHIN(place (State or Foreign
Director		216-38-0083 ^{1□M 2} ♥F 88	Yrs. Months Days Hours Min.	MAY 2, 1	918 MAR	YLAND
p .		Usual Residence of Decedent	wn or Location		T,	0d. Inside City Limits
sho	7					1 ☐ Yes 2 ☑ No
the N	ect	MARYLAND WASHINGTON 10e. Street and Number	BOONSBORO 10f. Zip Code	10a	. Citizen of What Coul	ntry?
3a or	ā	6038 ROHRERSVILLE ROAD	21713		U.S.A	,
death ms 2	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (St If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Americ	can Indian,
is 5, intally failed & I.E. I.S. 1000. Is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23s or 28s-f show other treumatic event, the Madical Expulper cust be notified at	by Fui	Armed Forces? 1 Never Married 2 Married 1 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	nicari, etc.)	Black, White,	etc. VHITE
sturel		15. Decedent's Education 16	a. Decedent's Usual Occupation	161	b. Kind of Business/In	
hin 72	piet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	king		ŕ
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ally allower the state of the s	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai		
should ind Men ind Men ind Men ind Men ind Men ind individual indi	ပ	JOSHUA PAUL BISER		DLA POFFEN		0.43
d 2 st d 2 st th and 7 ls n treun			b. Mailing Address (Street and Number or Ru.			
1 and Health Health tem 27		20a Method of Disposition 20b. Place	of Disposition (Name of	ONSBORO, Date 200	C. Location - City or To	21713 own, State
Pages nent of I		1 X Burial 2 Cremation 3 CHemoval from State	BORO CEMETERY 4/2	4/2007 BC	OONSBORO, I	MVDAIVNU
Dealth Doc, 1919 permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any Injury or other tre ance.		21. Six hature of Fin and Service Licensee Paul M. Dean	22. Name and Address of Facility	7606 01d	National	Pike
2 403 60		23a. Part1. Enter the disease, or complications that caused the death. Do		-	o, Marylan	d 21713 Approximate
2 1		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	That ariter the mode of dying, such as cardiac	or respiratory arrest,	•	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death) Distolor as a donsequence	a off:		-	10 day
Examiner		Jack as a second	cular excident			10 L
	Jer	Sequentially list conditions, if any, leading to immediate gause. Enter Underlying				
ate be executed hysician and the burial-fransit	Examiner	that initiated events c.				
be exe	E	resulting in death) Last Due to (or as a consequence	a of);			
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n certifi nding use as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	arv
The could us, F.C. BOX 00100, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 Ves 2 No 4 Pregnant at time of death	h 3 Ectopic pregnancy 5 Other (specify)		Month	Day Year
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s tha gned	by P	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	
requires t	ted			1 🗆 Yes	2√2No 3 Prot	pably 4 □Unknown
law r nas be	Completed			24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
The cate h	Co			performed		2 🗆 No
vicien: certifica rector, p	Be	25. Was case referred to medical examiner?	Others	th (Check only one)		
Phys raldii	To I	TEL TES SEINO TEL INPAtient 2EH/C	Outpatient 3 DOA 4 Nursing H. Time of 28c. Injury at Work?	ome 5 Residence 28d. Describe how	e 6 Other (Special	ý)
th.: Afte	Certification:	1 ☑ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury Work? M 1 ☐ Yes 2 ☐ No		. ,	
Attendi	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Stree City or Town, S	at and Number or Rura	al Route Number,
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To the Hospitel or Attending Physicien: The law requires that the death cer within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	edical	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one)	ge, death occurred at the time, date and place, and/or investigation, in my opinion, death occu-	, and due to the caus rred at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
		A Mandant 100	D32518		4.23.07	
4.4		30. Name and address of person who completed cause of death (Item 23a				
3H-5			Drive, Keedysville,	MD 21756		
Sta Regist		31. Date filed (Month, Day, Year) APR 2.3 2007 32. Registrar's Signature	1. 1. 1. 11			
ricgist	AEII	APR 2 3 2007 Brew B.	ppoor			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** Hull Ronald M. Sr. April 12, 2007 5:30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico 9025 Star Road Delmar 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 6/25/1944 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1(XM 2□ F 215-44-6586 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or iteme 23a or 28a-f ehow appringing or other traumatic event, the Modical Exempres must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9025 Star Road 21875 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Section 1 Sec 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: African/ 3 Widowed 4 Divorced American

16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hull's Salvage owner/operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonard T. Hull Bertha Coulbourne 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38001 Old Stage Rd., Delmar, DE 19940 19a. Informant's Name/Relationship (Type, Print) Ronald Hull Jr/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Springhill Memory 4/21/07 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) Gardens 22. Name and Address of Facility Holloway Funeral Home Professional Association 21. Signature of Funeral Service Li 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC NON-SMALL CELLIUNG MONTHS /Medical Due to (or as a consequence of): Examiner Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Be Completed by Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Yes 1 ☐ Yes ours after death.

Neral Diractor: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manne Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 L atural 1 Tes 2 No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature and title of certifier 29c. License number 00062911 APRIL 12, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GUTIERREZ 14 15 504174 DIVISION SUITE 31. Date filed (Month, Day, Year) 32 Registrar's Signature 1 8 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Degedent's Name (First, Middle, Last) Day Month Year **Physician** 2335 TARRISON 04 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOSP, TAL Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Hours 1**X**M 2□F 24-12-2007 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 7es 2 No Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 21209 Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health al Important: If item 27 is any injury or other trau BALTO, My 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State HOSPITAL 4 □ Donation 5 Other (Specify) HOSPITEL 22. Name and Address of Facility JINA DISPOSAL 21. Signature of Funeral Service Licensee 2401 W. BelveDeRe Ave BALTIMORE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final day Physician severe prematurity disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and Due to (or as a consequence of): Box 68760 Be Completed by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 2 | Fetal death Year in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 4 Unknown 1 Yes 2 No 3 Probably funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed; 2 No 1 ☐ Yes Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Division or After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Insert Section of the Desis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) manuellenon MD April 12, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sixui Hospital of Baltime Julianne Kenton, HD 2401 w Belvedere Ave Bultimore 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician L**riate 2007 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner Washington Adventist Hospital Montgomer 5. Social Security Number **Funeral** Hours 1 ☐ M 2 ☐ F Director 228 42 4098 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a State 10b. County Yes 2 No Directo Yrince Georges andover 10g. Citizen of What Country? 10e. Street and Numbe item 27 is marked other than "natural" or Items 23a or other traumatic event, the Medical Examiner must be USA Village Drive 2210 D785 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23. 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. THE TORCES?

☐ Yes 2 No
Yes, Give
ear or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 Specify: Black þ 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Iriade Waldorf MD 1180 Yoppy Hills Ct. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any Injury or of once, 1 ☐ Burial 2 Cremation 3 ☐ Removal from State politan 4/21/07 Alexandria, VA 22. Name and Address of Facility Greene Funeral Home Metropolitan 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Nelson E 814 Franklin St. Alexandria, VA 22314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final AKDIOP WLM DHEAR **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Certification: To Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an ate has b autopsy 2 🔀 No this certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 X ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and fitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DHYENAKA 7325A HAOTOVER FARKWAY GREENBELT MARYLAND 20770 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Hev 1/2001

ORIGINAL

thin 24 hours enter control of the Funeral Director Af (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D38892 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SY ITE 130

PAMELA FOX BANDARD, MD 11110 MEDICAL CAMPUN ADRA, 10H-32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

			1 - For State Registrar	State of Maryla	nd / Depa	artment of	Health and Me		ene 0 0 7	14370
~ ,			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
3.	Physici /Medio		JOHN	D.	JOHNSO)N SR	•	APRIL	16 2007	7:30 P M
	Examir		4a. Facility Name (If not institution, give s				or Location of Death		4c. County of Death	
-6		<i>d</i> =	PRINCE GEORGE'S 5. Social Security Number 6. Sex		for a bindbaland	CHEV		0. Data of Birth		GEORGE'S
	Funeral Director			7. Age (in yr.	s. last birthday) Yrs.	Months Day		8. Date of Birth (Month, Day, Y JULY 6		place (State or Foreign intry)
344			Usual Residence of Decedent	70				JULI 0	1926 LUUI	SIANA
	arylan	_	10a. State 10b. County		City, Town or Lo	cation				10d. Inside City Limits
	Se-f	ac to	MD PRINCE GE	ORGE'S	PALMER					1X Yes 2 □ No
	a or	Ö	10e. Street and Number 7722 MUNCY ROAD			10f. Zip Code 2078.		109	U.S.A.	intry?
	within 72 hours after death with the Maryland ane. then "naturel", or items 23a or 28e-f ehow ite Madical Examinat robal be mailfied at	by Funeral Director		12. Was Decedent Ever in	U.S. 13, 1	Was Decedent of	Hispanic Origin? (Spec	cify Yes or No-	14. Race - Ameri	ican Indian,
9	or ite	F	1 ☐ Never Married 2 Married	Armed Forces? 1 XYes 2 □ No NA	VY		iban, Mexican, Puerto F	Rican, etc.)	Black, White	
93	arel', c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ N	о Ѕреспу:		Specify: B	BLACK
21215-0036	"natu	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occ kind of work don DO NOT use reti	e during most of working	16	b. Kind of Business/Ir	ndustry
12	within then then	ding	Elementary/Secondary (0-12)	College (1-4or 5+)	/// //		'AL CLERK		GOVERNM	ENT
D 2	other	BeC	17. Father's Name (First, Middle, Last)			1051	18. Mother's Name	(First, Middle, Ma		
/lar	Venta Venta Prked	To B	JOHN JOHNSON				BEULLAH	ELRIDGI	Ξ	
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other then "naturel", or Items 23a or 28e-f show or other traumatic event, It is Mudical Examinating the notified at		19a. Informant's Name/Relationship (Type				et and Number or Rural			
	1 and 1 Health em 27 other tr		HENRIETTE W. JOHN			ZZ MUNUX sition (Name of	ROAD PALM		MAKYLAND c. Location - City or T	
nor	Pages nent of h int: If Ite		1 Burial 2 ☐ Cremation 3 ☐ R	amoval from State	cemetery, crer	natory or other p		11.	•	
Baltimore,	그 된 된 중		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License				ress of Facility J.		HELTENHAM, INS FUNERA	
Ba	Department of the partment of		K. N. H-	a 00			OOVER ROAD			
400			23a. Part1. Enter the disease or compli- shock, or heart failure. List only on	cations that caused the de-	ath. Do not ent	er the mode of d	ying, such as cardiac or	respiratory arrest	,	Approximate Interval Between
	Physician		tmmediate Cause (Final disease or condition	Antal Co	ardia	e ar	ry Horia	,		Onset and Death
Š,	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):					
ш	*	_	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	augus of):					
	nsit	Examiner	Cause (Disease or injury	Due to (or as a conse	quence or).					
Ć.	execunand and ial-tra	Еха	that initiated events c resulting in death) Last	Due to (or as a conse	equence of):		·			
8760,	cate be executed physician and the burial-transit	dical	L							
9	artifica ing ph e as th	Med	IF FEMALE:							
Вох	eath certific attending p for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregi 1☐Live birth 2☐Fe	tal death 3	Ectopic pregnan	ісу		23d. Date of deliv Month	ery Day Year
o	that the de ed by the a detached i	ysic	1 Yes 2 No	4☐ Pregnant at time of 9☐ Unknown	death 5	Other (specify)				•
۵.	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as		Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause o	given in Part I.	23e. Did tobac	co use contribute to t	the cause of death?
rds	quires on sign uld be	ed by						1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Unknown
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Ĕ		E O						autopsy performe	d3 death?	ompletion of cause of 2ED No
/ita	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?				26. Place of Death		77	
ot	Physi this c	5	1 Yes 2 No		ER/Outpatien	t 3 DOA	ther: 4 Nursing Hom			fy)
ם	ding I h. After funer	tion	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	W	uryat 2 ork? □Yes 2□No	8d. Describe how	injury occurred	
Division of Vital Records,	ten Jeat tor: the	flca	3 Suicide 6 Could not be	28e. Place of Injury - At	home, farm, str			8f. Location (Stree	et and Number or Run	al Route Number,
	al or A s after ol Dire	Certification;	4 Homicide determined	building, etc. (Spec	eify)	•		City or Town, S	State)	
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edical (29a. Certifier (Check only 2 Medical Examin	ician: To the best of my kr er: On the basis of examin	nowledge, death	occurred at the	time, date and place, a	nd due to the caus	se(s) and manner as s	stated.
	To the P within 24 To the F complete	Medi	one)	and manner stated.						
1	T wit		29b. Signature and title of certifier	-			nse number		Date signed (Month,	
'n	(_30. Name and address of person who co	mpleted cause of death (Ite	om 23a) /Time	Print	10701	4	7-17-0	1+
K	(5)		Dr. Harry & Utle	3001 H05P	tal D	rive C	18957 heverly	Med 2	0785	
1	Sta	_	31. Date filed (Month, Day, Year)	an Designate City	natu					
1.4	Registr	ar	APR-192007	Threem D.	Ope B					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEN THE #24a, per VERB., 500, 5/3/07, WS

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death KEHOE **Physician** PRI /Medical 4a. Facility Name (If not institution, give street and number) **MEDICAL** 4b. City, Town, or Location of Death 4c. County of Death Examiner SBAYVIEW BAUTIM Index 1 Year If Under 8. Date of Birth (Month, Day, Year) 10/15/1933 **Funeral** Days Hours 73 220-56-0974 Director Korea Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ehow. in then "netural", or iteme 23a or 28a-f ehov The Medical Examinar must be notified at 1 ☐ Yes 2X No Completed by Funeral Director MD Harford Aberdeen 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 U.S.A. 3508 Garrett Ct. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Oriental 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home 10 i. Pages 1 and 2 should be filed vitnent of Health and Mental Hygie trant: If Item 27 le marked other I jury or other treumatic event, II other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be UNK UNK ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3508 Garrett Ct. Aberdeen, Maryland 21001 Richard E. Kehoe (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Gdns. 4/28/07 Aberdeen, Maryland 21. Signatup of Funeral Service L ²² Name and Address of Facility Funeral Home, P.A. Aberdeen, Maryland 21001-3399 rart1. Enter the disease, or complic tions that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arres Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Be Completed by Physician/Medical Examiner burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed JEUMONI Due to (or as a consequence of) Box 68760, use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy detached for Month Day Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 8 BSTRUCTIVE DISEASE 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 No 1 🗌 Yes Division of Vital the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Affer 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat Funeral Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide pelili Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier within 24 ho To the Func completely f 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4940 EASTERN AVE., BAUTIMORE, MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAULAINE Day, Year) 3 200 31. Date filed (Month, 32. Registrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** PM 11:15 Ellen Kinzer 25, 2007 Apri /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown 8. Date of Birth (Month, Day, Year)
April 23,1929 | 9. Birthplace (Country)
West Virginia If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 🕅 F 233-40-9405 78 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Boonsboro Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9252 Mountain Meadow Drive 21713 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Maryland 21215-0036 Specify Specify: þ 3 X Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melvin James Mongan Mazie Mae Everitts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is in any injury or other traum once. P.O.Box 1241 Hagerstown, MD Tony Kinzer/ Son 21741 Baltimore, 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 4/28/2007 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumonia disease or condition resulting in death) /Medical Lue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and burial-trat resulting in death) Last Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year ō Day in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 2 No been signed by the should be detached or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 2 No 3 Probably 4 Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed After this certificate 1□ Yes 2 DNO 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? or Attending (Month, Day Year) Division 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: A 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nagerstown 5. Saxena 38 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 03 Registrar

	1 - State Registrar	- /pm; 4 & B2 - 4 - 4 - 1	0	aryland / Dep Ce	ertificate of		Re	eg. No.2	17	14373
sician edical	1. Decedent's Nam		•				2. Date of Deat Month April	Day	Year 007	3. Time of Death
miner	4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o	r Location of Death		4c. County		0000 11
	Holy Cr	oss Hosp	ital		Silver	Spring		Montgo	omery	,
eral	5. Social Security N		Sex 7. A	ge (In yrs. last birthda			8. Date of Birth (Month, Day,	Year)	9. Birthpl Count	ace (State or Foreign
tor	574-62-2		TO IN 2	55 Yrs.			March 17	7, 1952	Ethi	.opia
_ı	Usual Residence o 10a. State	10b. County		10c. City, Town or I	Location				10	Od. Inside City Limits
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Funeral Director	10e. Street and Nu		iciy	DIIVEI	10f. Zip Code		10	0g. Citizen of W	hat Count	try?
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by Fu		ried 2 Married	1 ☐ Yes 2 ☑ If Yes, Give	No	1 □ Yes 2 No	Specify:	5 v 110ari, 010.)		Blac	
d b	3 X Widowed		Year or Dates:	16a Daa	adantia Harri Oan			F		
lete		15. Decedent's cify only highest of	rade completed)	(Giv	edent's Usual Occup re kind of work done DO NOT use retired	during most of wor	king	16b. Kind of Bu	siness/Ind	lustry
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Be C	17. Father's Name	(First, Middle, La			DIIVOI	18. Mother's Nam	ne (First, Middle, M			k)
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		Mariam /	Friend		Longwood		alapan, N	IJ 07726)	
any many or other reduitative event, the medical Examines fines the inclined at once. To Be Completed by Funeral Director	20a. Method of Dis 1 ☑ Burial 2		☐Removal from State		position (Name of rematory or other place			20c. Location - (•	,
in i	4 ☐ Donation	5 Other (Spec	cify)	Gate of	Heaven Ce	m. April	19, 200	7 Silve:	r Spr	ing, MD
once.	21. Signature of Fi	ineral Service Lic	ensee	/	22. Name and Addre					_
5 G	220 Port1 Enters	nelse l) nongo		7400 Georg				n, DC	
	shock, or hea	art failure. List on	mplications that cause ly one cause on each I	ine.	nter the mode or dyir	ng, such as cardiad	or respiratory arre	est,		Approximate Interval Between Onset and Death
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ner			Due to (or as	a consequence of):						
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Examine	Cause (Disease or that initiated events	injury	C							
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ete							24a. Was ar	0.41- 14	(
Completed			-				autops perforn	y p	rere autop nor to com eath?	osy findings available apletion of cause of
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0 0	examiner? 1 ☐ Yes 2 🔀		Hospital: 1 D Inpati	ent 2 🔀 ER/Outpatie	ent 3 DOA Oth	or:	th Check only one ome 5 Reside		. (0	
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atio	1 X Natural 2 ☐ Accident	5 ☐ Pending investigati	(Month, Da	ay Year) Injury		Yes 2 □ No				
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Cer			3,					, Olale)		
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0 .9	one)		and manner si	ated.	29c. Licens					
Medic	29b. Signature and	and of certifier	0.1		}			9d. Date signed		
Medical Certification: To Be C	· ~ A	10110	1/1/a CX	1.	- 1	- 6 1/7		10/1	<i>i</i> >	フヘヘフ
Medic	▶ 	mu	Collon	ely, M.	-	05763	0	04-	13-	2007
Medic		ress of person what Arun,	o completed cause of o	death (Item 23a) (Type 1 Georgia	e, Print)					

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2:25 pM April 15, 2007 Ronald Looho /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1 X M 2 D F Director 62 None December 12,1944 Bogor, Indonesia Usual Residence of Decedent 10c. City, Town or Location a or 28a-f show t be notified at 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Director Ponbok Gede Indonesia Jakarta 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ns 23a must b 2#15 Jatibening, J.L. Pembangunan Funeral 001-005 Indonesia ral", or items 2 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🔼 No 2 Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Asian Completed the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 **Economist** Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland Be 27 is marked of traumatic even 2 Piet Hein Looho Augustine Noya 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Magdalena Hopkins - Sister item 2 6506 Democracy Blvd., Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o
once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pondok Kelaba 4/24/2007 Jakarta, Indonesia 21. Signature of Funeral Service Licen - e 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a Part1. Sinter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate cause (Final Physician disease or condition resulting in death) Intracranial Hemorrhage /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit death certificate be executed Exami Due to (or as a consequence of) Box 68760. Physician/Medical as the attending I IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) I□Yes 2□No Division or Vital Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s performed? Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No ۲ 1 Inpatient 2 I ER/Outpatient 3 IDOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 K Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral D 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a D62949 April 18, 2007 ss of person who complete cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

2007

19

Md) Settl

4115107

ennald

Natasha Haag, M.D., (8600)Old Georgetown Road, Bethesda, Maryland 20814 gistrar's Signature

		-	For State Registrar	State of Mary		artment of H tificate of L		R	eg. No.	07	143	75
.,	Physicia	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month April	Day 23	2007	3. Time of 5:20	
	/Medic	al	Norma Lorraine Les 4a. Facility Name (If not institution, give			4h City Town or	Location of Death	Аргтт		ty of Death	7:20	АМ
	Examin		18747 Preston Road			Hagerst			1	Vashin	gton	
	Funeral		5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 03/26/1	Year)	9. Birth	place (State o	r Foreign
	Director		216-14-5258	□M 2 🔼 F 8	35 Yrs.	Wioritis Days	1100.0	03/26/1	922		VA	
	pur *	-	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation					10d. Inside Ci	ty Limits
	Manyl fede	0	MD Washing	ton	Hagersto	wn					1 🗆 Yes	2 X No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o		ntry?	
	th with	a D	18747 Preston Road	d 		21742				US		
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itema 23a or 28a-f ehow aumatic event, Ir a Medical Exactivational be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		ecify Yes or No- Rican, etc.)	Spec	ace - Ameri lack, White, cify: W		
21215-0036	thin 72 hours e. en "natural", Medical Exa	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	flucation de completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most of work ()	ing	16b. Kind of			
21	ygien rt, tr	Con	12 17. Father's Name (First, Middle, Last)		A	dministra	18. Mother's Nam	e (First Middle			Office	
Maryland	m - 0 5	Be	George Albert Gro				Bessie					
<u> </u>	should be fund Mental Is marked o	ဥ	19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street	and Number or Rur	al Route Numbe	r, City or Ton	vn, State, Zi	p Code)	
<u>8</u>	alth ar 27 is		Christopher C. Cl	ine / Son	4 A	rthur Str	eet, West	t Hampto	n Beac	ch, NY	11978	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked eny Injury or other traumatic ex once.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 2)	Removal from State	Smithsburg	crenatoriu	m April	24, 2007		urg, Ma	ryland	
Balti	permit. Departm Imports eny Inju		21. Signature of Funeral Service Licer	nsee /		2. Name and Address No. Po						
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the one cause on each line.	death. Do not ent	ter the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximat Interval Bet Onset and	ween
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):						100	
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	onsaquenne of):							
38760,	ficate be executed physicien and is the burial-transit	dical Exa	resulting in death) Last	Due to (or as a co	onsequence of):							
~	ntificating physics the	a a	IF FEMALE:									
P.O. Box	The law requires that the death certific ate hes been signed by the attending p page 2 should be detached for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 Live birth 2 4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	<i>'</i>			Date of deline	,	Year
	uires that signed by	5	Part II. Other significant conditions of	contributing to death but n	ot resulting in the u	ınderiying cause gıv	en in Part I.	23e. Did to	obacco use c res 2 ☑No	,	the cause of obably 4 \square	
Records,	The law requirate hes been sipage 2 should i	Completed						24a. Was autop perfo 1 ☐ Yes	rmed?	prior to c death?	topsy findings ompletion of a	available cause of
ita	Physicien: r this certifica ral director, p	Be	25. Was case referred to medical examiner?			104	26. Place of Dea	th (Check only o	ne)			
) (hysic this co	၉	1 ☐ Yes 2 ☐ No	L-,	2 ER/Outpatie	ni 3LIDUA		ome 5 Resident			ufy)	
n C	Jing F After funer	lon:	27. Manner of Death 1 Active 1 S Pending investigation	28a. Date of Injury (Month, Day Ye	ear) 28b. Time o	Wor	k? Yes 2 □No	200. Describe i	now injury oo	cunea		
Division of Vital	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	99 Place of Injuny				28f. Location (S City or Tox	Street and Nu wn, State)	ımber or Ru	ral Route Nur	nber,
	Hospitel 24 hours 2 Funeral etely filled	edical C	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exa	hysician: To the best of n miner: On the basis of ex and manner stated	amination and/or in	th occurred at the timestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and date and plac	manner as ce, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of Conting	5	>	29c. Licens	se number	6	29d. Date sig	med (Month	n, Day, Year)	7
25	H-10		30. Name and distress of person with	completed cause of deat	th (Item 23a) Type	Print) (VA)	a Avo	nue l	tasp	Mou	4. A	0
AND SHE	San Jahren	ate rar	31. Date filed (Month, Day, Vear)	32. Registrar's	Signature	beck				2	174	2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Lilliston 2007 April 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Inder 1 Year | If Under 24 Hrs. Wicomico Nursing Home Wicomico 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Months 1 ☐ M 2 🔀 F 83 215-26-4642 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hyglene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show important: If then 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County PARSONSBURG Director MARYLAND Willomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 32943 21849 USA ongRidge Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2⊠ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Black þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NONE Domestic 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KODINSON HETTIE MAE _EWis BAKE ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DEAN ChESAPEAKE, NIECE MARY GEORGE QUAY Kina 20b. Place of Disposition Name of cemetery, crematory or other place) Date / 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State CEND. Spring hill 4-21-0 HEBRON, 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home 821 West Rd. Solis. Md Blade Stewart Slewar 23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** OBSTRUCTIVE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23d. Date of delivery 3 ☐Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 1□ Yes ald No

To the Hospital or Attending Physlcian: The law requires that the death certificate be executed Be Certification: To Director: After this within 24 hours a Medical

24b. Were autopsy findings available prior to completion of cause of death? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes ₽ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann o Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 A Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

and manner stated. 29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

3. Time of Death

8:40 A

9. Birthplace (State or Foreign Country)

DE ALOARE

10d. Inside City Limits 1 ☐ Yes 2 ☑No

VA 23325

Approximate Interval Between Onset and Death

Day

Year

4 Unknown

2/801

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

614 Eastern Shore Drive, Salisbury, MD 21804

State Registrar

Maesha Thimmarayappa, MD

31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** WELBOURNE ATWOOD MOLLISON , JR. 4-4-07 7:43A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Age 9. Birthplace (State or Foreign **Funeral** Year) Months 1**反**M 2□F 85 349-16-6218 Director 7-15-21 OHIO Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir then "natural", or itams 23a or 28a-f ehow the Medical Examiner must be notified at SILVER SPRING Yes 2 No Funeral Director MONTGOMERY MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? S. 20910 U. Α. 1900 LYTTONSVILLE RD. #212 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify:BLACK þ 3 Widowed 4 Vivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) YRS (1-4or 5+) PFIZER CHEMIST permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event <u>900.8</u>: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PATRISA COWAN WELBOURNE A. MOLLISON, SR. P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1900 LYTTONSVILLE RD.#212 S.S.MD.20910 PAUL MOLLISON - SON 20a. Method of Disposition
1 Buriał 2 Fremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State LEE CREMATORY 4-9-07 CLINTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PINCKNEY-SPANGLER F.H. 524-8TH ST., N.E.WASH., D.C. 20002 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner nding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 4☐Pregnant at time of death Division of Vital Records, P.O. detached 1 Yes 2 No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown pleted 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Com performed 2 No 1 ☐ Yes 2 ☐ No Director: After this certific Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 1 Umpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 2 Accident investigation М 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled 29a. Certifier Tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year C person who completed cause of death (Item 23a) (Type, Print) 30. Name 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 15^{Day} 2007 Jeanne M. McAllister 4:20 A 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 1 M 2 X Days Months Maryland 51 214-68-9883 10,1955 Dec. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1X Yes 2 □ No MD St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20636 43248 Plainview Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 Tyes 2 No Specify: 3 ☐ Widowed 4 💆 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry State Attorney Office Elementary/Secondary (0-12) 12 College (1-4or 5+) St. Mary's County Admin. Assist. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward J. Walsh Mary Frances McGarvey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward J. Walsh, Jr. / brother 693 Winding Stream Way #203 Odenton, MD. 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 04/18/2007 Alexandria, VA. 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licens 6512 NW Crain Hwy. Bowie, MD. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition NONHADOKIN 5WOWT disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23d Date of delivery

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

r 28a-f show notified at

"natural", or Items 23a or edical Examiner must be r

the Medical

death

filed within 72 hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Mea

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

2

Examiner Physician/Medical the as nse Completed Be

2

Certification:

Medical

certificate be executed burial-trar attending physician Por ed by the a detached f peen has Attending Physician:

After

filled in by the

within 24 hours after death To the Funeral Director:

P.O. Box 68760.

Division or Vital Records,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗷 No 9 Unknown

25. Was case referred to medical examiner?

3 ☐ Suicide

4 Homicide

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

9□Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Tes 2000 3 Probably 4 Unknown

Day

Year

Month

28c. Injury at Work?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 26. Place of Death (Check only one)

1 Inpatient 2 No 1 TYes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28h. Time of 1 Natural 5 ☐ Pending investigation 2 Accident 6 ☐ Could not be

Hospital:

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29a. Certifies 🎉 lifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sign

29d. Dale signed (Month, Day, Year)

30. 31. Date filed (Month, Day, Year)

State Registrar

APR 1 9 2009



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4. 2. Date of Death 1. Decedent's Name (First, Middle, Last) NORMAN WARNELL MASSIE 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deal DOCTORS HOSPITAL PRINCE GEORGES LANHAM If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. 1 → M 2 □ F 578-76-2021 50 APRIL 6 1957 WASHINGTON, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 No MDPRINCE GEORGE'S LANHAM 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A 14. Race - A GOODLUCK ROAD # 202 20706 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No BLACK Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th MECHANIC PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NORMAN EDWARD MASSIE NANCY BURTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NORMAN EDWARD MASSIE/FATHER 3412 EDWARDS STREET SPRINGDALE, MARYLAND 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 4 Donation 5 Other (Specify) CEDAR HILL CEMETERY 4/19/2007 SUITLAND, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B.JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or commissions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition HEPATIC FAILURE

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

rral", or items 23a or 28a-f show I Examiner must be notified at

Injury or other traumatic event, the Medical

Department of Health and Mental Hygie Important: If item 27 is marked other t any Injury or other traumatic event, th

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene.

Director

Funera

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death with the Maryland

attending physician for use as the buria after death filled in by the

law requires that the death certificate be executed

the Hospital or Attending Physician:

within 24 hours a

Division or Vital Records, P.O. Box 68760,

	resulting in death)	Due to (or as a consequence of):			
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2	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of).			
	Cause (Disease or injury that initiated events				
X	resulting in death) Last	Due to (or as a consequence of):			
20		d			
5					
lysiciai / m	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic p 4 ☐ Pregnant at time of death 5 ☐ Other (s) 9 ☐ Unknown		23d. Date of o Month	delivery Day Year
ed by ri	Part II. Other significant conditions IMMUNODEFICIEN	contributing to death but not resulting in the underlying of CY_SYNDROME	cause given in Part I.	23e. Did tobacco use contribute	e to the cause of death? Probably 4 🔀 Unknow
aldillo				24a. Was an autopsy performed? 1 Yes 2 No 1 □ Y	
9	25. Was case referred to medical examiner?		26. Place of Death (Ch	eck only one)	
0	1 Yes 2 XNo	Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ Do	OA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (S	pecify)
ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M		Describe how injury occurred	
erme	3 ☐ Suicide 6 ☐ Could not be determined.		y, office 28f. L	ocation (Street and Number or Cify or Town, State)	Rural Route Number,
dical		hysician: To the best of my knowledge, death occurred miner: On the basis of examination and/or investigation and manner stated.			
E	20h Signature and title of cortifier	200	c License number	29d Date signed (Mo	onth Day Voer)

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MARTIN WELTZ M.D.

D23743

7525 GREENWAY CENTER DRIVE GREENBELT, MARYLAND

16, 2007

20770

APRIL

			For State Registrar	State of Ma	ıryland / Depa <i>Cer</i>	artment of H <i>rtificate of l</i>			iene	7 14380
	Physici	an	1. Decedent's Name (First, Middle, La	st)				2. Date of Deatl Month		3. Time of Death
*	/Medic			mes Middleton	n			April 3	, 2007	5:20 p M
Į	Examin	er	4a. Facility Name (If not institution, giv	ŕ			Location of Death		4c. County of D	
	Funeral	-	Montgomery General 5. Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year	Iney If Under 24 Hrs.	8. Date of Birth (Month, Day,	Montgon 9.	nery Birthplace (State or Foreign Country)
	Director		579 - 18-6770	I □ M 2 🛣 F	85 Yrs.	Months Days	Hours Min.	November 8		Country)
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
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	r 28a-	Directo	Maryland Monts 10e. Street and Number	gomery		Laytonsvi 1	11e	10	g. Citizen of What	Country?
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	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13. V	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto l	cify Yes or No- Rican, etc.)		merican Indian, Vhite, etc.
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0	1 ☐ Yes 21K No	Specify:		Specify:	
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	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at		Kevin W. Middleton				Laytonsvil			e, 2ip 00de)
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Baltimore,	permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service Lion	nsee	Hi	. Name and Addres nes-Rinaldi 800 New Hau	Funeral Ho	ome, Inc.	r Spring N	Maryland 20904
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5	tal or rs afte al Dir ed in	Certification:	- Пописка	building, etc.	Home		1	City or Town,		nsville,MD 20882
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) 1	ysician: To the best of niner: On the basis of and manner stat	examination and/or inv	occurred at the time vestigation, in my op	ne, date and place, a pinion, death occurre	and due to the ca ed at the time, da	use(s) and manner ite and place, and o	r as stated. due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Mo	onth, Day, Year)
1	5		14/2	17		D1	8726		April 17,	2007
			30. Name and address of person who		, , , , ,	,			20.00	
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¥	Registr	a	APR 192	007 Jenes	e B A	eres.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 0645 AM Mc Donnell 2007 William /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Months Days Hours Min. Director 213-16-2944 85 11/13/1921 NY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show Inty or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits MDMontgomery Rockville 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701 Medical Center Drive #129 20850 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: White þ Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: WW II Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Executive</u> National Geographic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Bernard McDonnell Annie E. Bosworth ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Barnes - Daughter 10311 Glen Road Potomac MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ▼ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 4/17/07 Falls Church, VA 22-Name and Address of Facility
Edward Sagel Funeral Direction Inc
1091 Rock Ville Pike Rock Ville MD 20852 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Acute. myocardia /Medical Due to (or as a conseque ce of): Examiner Pheumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dire to (or as a consequence or, The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical (F FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 s autopsy perform 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 Hospital: No 1 Impatient 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Month, Day 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated.

To the Hospital or Attending Physician: completely filled in by the funeral director, within 24 hours a

> State Registrar

29b. Signature and title of certifie

Brandon

31. Date filed (Month, Day,

MD

Medical

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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19 2007

29c. License number

D0064029

Drive, Rockville, MD

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	Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department: If Item 27 Is marked other than "natural", or items 23a or 28a-f show and injury or other traumatic event, the Medical Examiner must be notified at one of once.	Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. any injury or other traumatic event, the Medical Examiner must be notified at one. To Be Completed by Funeral Director	Physician /Medical Examiner 1. Decedent's Name (First, Middle Richard Lero 4a. Facility Name (If not institution Washington Co Washington Co Funeral Director 5. Social Security Number 214-42-1068 Usual Residence of Decedent 10a. State 10b. County Maryland Wash 10e. Street and Number 331 S. Potoma 11. Marital Status 1 Never Married 2 Marrial 3 Widowed 4 Divorced (Specify only higher Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Edgel L. Moo 19a. Informant's Name/Relations Melissa M. Loo 20a. Method of Disposition 1 Burial 2 McTermation 4 Donation 5 Other (S 21. Signature of Funeral Service 23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Physician / Medical Examiner 1. Decedent's Name (First, Middle, Last) Richard Leroy Moore, Sr. 4a. Facility Name (If not institution, give street and number) Washington County Hospital 5. Social Security Number 6. Sex 214-42-1068 Usual Residence of Decedent 10a. State 10b. County Mary I and Washington 10e. Street and Number 10e. Street and Number 11. Marital Status 10e. Street and Number 11. Marital Status 10e. Street and Number 11. Marital Status 10e. Street and Number 11. Marital Status 10e. Street and Number 11. Marital Status 10e. Street and Number 11. Marital Status 10e. Street and Number 11. Marital Status 10e. Street and Number 11. Marital Status 10e. Street and Number 11. Marital Status 10e. Street and Number 11. Marital Status 10e. Street and Number 11. Marital Status 10e. Street and Number 11. Marital Status 10e. Street and Number 11. Marital Status 10e. Street and Number 11. Marital Status 10e. Street and Number 11. Marital Status 10e. Street and Number 11. Marital Status 10e. Street and Number 11. Marital Status 10e. Street and Number 11. Marital Status 10e. Street and Number 11. Marital Status 10e. Street and Number 12. Was Decedent 12. Was Decedent 12. Was Decedent 13. Marital Status 10e. Street and Number 12. Was Decedent 14. Marital Status 10e. Street and Number 12. Was Decedent 15. Decedent's Education (Specify only highest grade completed) 11. Marital Status 11. Marital Stat	Physician Medical Examiner	Physician Indicated Indi	Physician Richard Leroy Moore, Sr. Richard Leroy Moore, Sr. Ab. City, Town, or Location of Death Richard Leroy Moore, Sr. Ab. City, Town, or Location of Death Hagerstown	Physician / Medical Examiner 1. Decedent's Name (First, Middle, Last) Ri chard Leroy Moore, Sr. As a Richard Leroy Moore	Physician Medical Examiner 1. Decedent's Name (First, Middle, Last) Richard Leroy Moore, Sr. 4. Facility Name (In or institution, give street and number) Washington County Hospital Funder I Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 2. Date of Death 1. Hunder I Yeer If Under 24 Hrs. Months Days Hours Min. Months

15H-2 State

31. Date filed (Month, Pay, Year) APR 24 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TUDITH MBAOUA, TW 251 E. Annie Lam St. 32. Registrar's Signature

Registrar

062588

April 22 th, 20

Hagershwn, MD

2007

		1_ For State	State of Marylan				Mental Hyg	iene	117	11.203
		Registrar		Cei	rtificate of I	Death		eg. No	001	14000
Physic	ian	Decedent's Name (First, Middle, Last))				2. Date of Dear Month	Day	Year	3. Time of Death 3:40 A. M
/Med			Mellott, Jr.		T				2007	5,20 M
Exami	ner	4a. Facility Name (If not institution, give				Location of Death	1	4c. Coul	nty of Death	n a + a n
NAME OF THE PERSON OF THE PERS		17535 Greenmeadov 5. Social Security Number 6. Security Number		last hirthday)	If Under 1 Year	gerstown I if Under 24 Hrs.	8. Date of Birth		Washi	
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anyland ahow		10a. State 10b. County	10c. City	y, Town or Lo	ocation				10	Od. Inside City Limits
Mar Mar	to	Maryland Washi	naton	H	Hagerstow	n				1 ☐ Yes 2 🛣 No
in the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen	of What Coun	try?
be filed within 72 hours after death with the Maryland tal Hygiene. I other than "natural", or tems 23a or 28a-f ahow avant, the Madical Exempler must be natified at	al	17535 Greenmeado	w Lane			21740			USA	
ems ems	Funeral	11. Marital Status	 Was Decedent Ever in U. Armed Forces? 	S. 13.	Was Decedent of H	ispanic Origin? (S In, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. F	Race - America Black, White, e	
or it	F	1 Never Married 2 X Married	1 X Yes 2 □ No 194 If Yes, Give	14-	1 ☐ Yes 2 🕱 No	Specify:		Spe		
ural'.	d by	3 Widowed 4 Divorced	Year or Dates: 192					100 100 1 - 1		White
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ges 1 and 2 should be filed within to f Health and Mental Hygiene. If Item 27 ie marked other than or other traumatic avant, Item	2	Arthur Emory Mello 19a Informant's Name/Relationship (Ty	OTT, Sr.	19b. Maili	ng Address (Street		<u>Catherii</u> Iral Route Numbei			
and 2 seath ar n 27 le		Jane E. Mellott -		17539	Greenme	adow Lan	e Hagers	town.	Maryla	nd 21740
ges 1 and t of Health If Item 27 or other tr		20a. Method of Disposition			sition (Name of matory or other place				on - City or To	
permit. Pages Department of Important: If Its any injury or o		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	removal from State		Mem. Par		25. 2007	Nillia	msport	, Maryland
permit. Pag Department Important: 1 any injury o		21. Signature of Funeral Service License			Sibone and Affide			,,,,,,,	шорог г	21795
permit. Departimport		1/ /1/	1					illiam	sport,	Maryland
Seu S		23a. Part1. Enter the disease, or compl	lications that caused the death						1	Approximate
Dhuaisian		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	· Can	211/28	accio	1011/-			Interval Between Onset and Death
Physician /Medica		disease or condition resulting in death)	a. Due to (or as a conseq	VUSC	u ac	uceeu	ance			4 rhonus
Examiner			Diakel	es -	Melli	tre 5			4	10ars
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cuted nd ransil	Examiner	Cause (Disease or injury that initiated events	Coronal	of C	Klery	1 Des	ease			YOURS
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e as 1	Med	IF FEMALE:			.					
ath ca	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3[Ectopic pregnancy	,			Date of delive Month	ry Day Year
the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of d 9☐ Unknown	eath 5	Other (specify)					
hat the detac		Part II. Other significant/conditions co	ntributim to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use c	ontribute to th	e cause of death?
requires t een signe	l by	Krosta	le Com	1004	/		1 🗆 Y	es 2 No	9 3 ☐ Prob	ably 4 □Unknown
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Atten deal ctor	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he	ome, farm, st	reet, factory, office		28f. Location (S	treet and Nu	ımber or Rura	l Route Number,
affe dint	Certification	4 Homicide	building, etc. (Specit	<i>y)</i>			City or Tow	n, State)		
sspitu hours nera y fille		29a. Certifier 1 Certifying Phy	sician: To the best of my kno	wledge, deat	h occurred at the tir	ne, date and place	a, and due to the c	ause(s) and	manner as st	ated.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2 Medical Exami	iner: On the basis of examina and manner stated.	uion and/or-in	vestigation, in my o	pinion, death occi	uned at the time, d	iate and plac	ce, and due to	ine cause(s)
To t	Σ	29b. Signature and title of certifier	2	0	29c. Licens				ned (Month, i	
		1 tille		UD	Hoo	45031		April	40 8	100-1
<i>21.</i>		30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type,	Print)	DA Charl	10-11	le He	afer &	town MD
DH-4+1		SHAHAB Z SA 31. Date filed (Month, Day, Year)	32. Registrar's Signa	/ / / /	c un		7	/	1	21742
S Regis	tate trar	APR 9 4 2			1		0	()	,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1300 PM 04 Noore 2007 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Wicomic Hospice at the Salisbur aKP If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5-6-3 Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F 216-34-765 MARYLAN'D Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic excess. 10c. City, Town or Location 10d. Inside City Limits 10h. County 1 XYes 2 No HEBRON Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21830 United States Funeral Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Completed by Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) FARMS allen Elementary/Secondary (0-12) College (1-4or 5+) FARM Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be am ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. Moore 413 Chestaut (Sister-in-Hebron, Md 21830 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State 4-21-07 Salisbury, md Green acres Mem. Park 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 917 W. Isabella Street Bennie Smith Salichipu and 21801 Service Lice Salisbury, md 21801 FUNEral Home calions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespectations on each line. 23a. Part1. Enter the disease, or companies shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed and the burial-tra Due to (or as a consequence of): Box 68760. the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s this certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ZZ No 2 ER/Outpatient 3 DOA မှ within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 27. Manner of eath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: Natural

Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide **ECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c, License number 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a), (Type, Print) E.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

ocestal

32. Begistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 12:00P M James Henry Price April 14 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Clinton Nursing & Rehab. Center Prince George's Clinton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 10XM 2□ F Months Hours Min. Director 223-12-1297 16, 1923 Virginia 84 Feb. Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ehow r then "naturel", or Iteme 23a or 28a-f ehov The Medical Examinar must be notified at 1 X Yes 2 No Directo Prince George's Maryland Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20785 6508 Asset Drive United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑(Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No þ Specify: **Black** 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) if Heelth and Mental Hygiene.
Item 27 Is marked other then
other traumatic event, Item 12th Private Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clinton Price Lena Braxton ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Price/Wife 6508 Asset Dr., Landover, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date permit. Pages
Department of F
Important: If Ite
ony Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 4/21/2007 Landover, MD 21. Signatu of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home lewar 4001 Benning Rd., NE Wash., DC 20019 23a. Part 1. See the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate value (Final disease or condition Physician Pneumonia resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Exam Due to (or as a consequence of) Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. detached 9 Unknown 9 ☐ Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atherosclerotic Cardiovascular Disease, 1 ☐ Yes 24 No 3 Probably 4 Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s 2MNo 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Wursing Home 5 Residence 6 Other (Specify) ۵ 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 XNatural 5 Pending in Hospies. _______n 24 hours after death.
the Funeral Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 ho

To the Fune
completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D52900 April 18, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Musa M. Momoh, M.D. 8700 Central Ave., Suite 301, Landover, MD 31. Date filed (Month, Day, Year) 32. Registrar's Sign State APR 1 9 2007 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death APMZ **Physician** MIPM Pinkner lizabeth 12 2007 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner PRINCE GEORGE'S CRESCENT CITY CENTER RIVERDALE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2**X**F Days Hours 578-52-3833 90 Yrs Director MARYLAND Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland Departmant of Health end Mental Hygiene. Important: If Item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Riverdale MD Yes 2□No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20737 East 440 9 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U,S Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 Specify: BLACK 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 2ND HOUSE WIFE 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN C. MEDLEY SR. ANNIE MERLIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS/DAUGHTER 201 53rd STREET S.E. WASHINGTON, DC 20019 AGNES 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/23/2007 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility J. B.JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER MARYLAND 20785 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure/List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ear Examiner Physician/Medical Examiner anding physician and usa as the bunal-transit or Attending Physician: The lew requiras that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as e consequence of): aftar death.
I Director: After this certificate has been signed. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Mulligus Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? TLY S 2 No 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Jursing Home 5 Pesidence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Kertifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Yeer) DO1852 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) Queensbury Rd Hyattsville M) 20781 Paul 4203 MS

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 9 2007

32. Registrer's Signature

			1 - For State Registrar		State of N	Marylar				lealth a	and Me		iene	2007		387
			1. Decedent's Name (First, Min	ddie, Last)								2. Date of Dear		. V	3. Time of I	Death
	Physici /Medio		Charles Pohl	e								Month April 1	Day 1	Year 2007	7:10	p_{M}
	Examir		4a. Facility Name (If not institu	tion, give s	treet and numbe	r)		4b. City	, Town, or	Location of		1111111		County of Death		
	Funeral		Fairland Adv 5. Social Security Number	6. Sex	7. 4		Rehab. last birthday)		r 1 Year	Sprin		8. Date of Birth	Year)		gomery place (State or intry)	
	Director		579-05-3139	134	M 2□F	86	Yrs.	WOITE	Days	riours				920 Wash		
	pur *		Usual Residence of Decedent 10a, State 10b, Cou	ntv		10c Ci	ty, Town or Lo	cation							10d. Inside Cit	
	•ho	ō	700. 51015	,		700.01	,, rown or co	JOANON							1 ☐ Yes	
	1he N	Director	Maryland 10e. Street and Number	Mor	tgomery		Sil	ver	Sprin Code	g		1.	0= Citi	zen of What Cor		-X
	with a or	ក្ត										'	og. Oil.	Zen or what con	antr y r	
	eath	ега	1030 Lanark		2. Was Deceder	t Ever in U	S 13 1	209		isnanic Orie	nin? (Snec	ify Yes or No-] .	USA 14. Race - Amer	ican Indian	
	ter d	5	1 Never Married 2 N		Armed Forces	?		If Yes, spe	cify Cuba	n, Mexican	, Puerto R	ican, etc.)		Black, White	, etc.	
98	urs al	by Funerai	3 ☐ Widowed 4 ☐ Divord		If Yes, Give Year or Dates			1 ☐ Yes	⊉ □ No	Specify:				Specify: Whi	ite	
21215-0036	72 hours after death with the Maryland natural', or iteme 23a or 28a-f ehow disal Examiner matte mullied at	ted		ent's Educ			16a. Deced	dent's Usu	al Decupa	ation			16b. Kii	nd of Business/I	ndustry	
215	within 7 ene. than "n	pie	(Specify only hig Elementary/Secondary (0-12			r 5+)	life.	kind of wi DO NOT i	ork done d ise retired	during most ()	t of working	9				
7	gien gien	Completed	, , , , , , , , , , , , , , , , , , , ,		College (1-4o 5 +			Pr	Lest				I	Religion	1	
힏	be filed htal Hygi od other event,	Be (17. Father's Name (First, Midd									(First, Middle, I		Sumame)		
yla	ould be Mental varked c	70	Charles C. Poh	le						Thel	.ma So	crivene	r			
Maryland	and and ls m		19a. Informant's Name/Relation	nship (Typ	e, Print)		19b. Mailir	ng Addres	s (Street a	and Numbe	or or Rural	Route Number	City or	r Town, State, Z	ip Code)	
	1 and Health tem 27 other tr		John C. Walsh	/Neph	lew					liff				Spring,		04
9	Pages 1 ar nent of Hea int: If Item 3 iry or other		20a. Method of Disposition 1 Burial 2 □ Cremation	n 3∏Re	moval from Stat		Place of Dispo cemetery, cren	natory or	other plac		Da pril	1te 20	20c. Lo	cation - City or 1	own, State	
Ξ	Pag ment ant:		4 □Donation 5 □Other			Mt.	Olive	t Cer	eter	У	200		Wash	nington.	DC	
Baltimore,	permit. Pages Department of Important: If It any Injury or o		21. Signature of Fune al Servi	License	300	0	F1	Name a	nd Addres	s of Facilit	ins E	uneral	Hon	ne Inc.		
				dien) Le	ree	50	00 Ur	iver	sity	Blvd.	. W.,	Silv	ver Sprj		
٠			23a. Part1. Enter the disease shock, or heart failure.	or complic ist only one	ations that cause cause on each	ed the deat line.	h. Do not ent	er the mo	de of dyin	g, such as	cardiac or	respiratory arri	est,		Approximate Interval Betw	veen
	Physician		Immediate Cause (Final disease or condition	a.	Pneum	onia									Onset and D	Balli
	/Medical Examiner		resulting in death)		Due to (or a	s a consec	uence of):									
	LAMITIME		Sequentially list conditions, if any, leading to immediate	b.												
	sit sit	Examiner	if any, leading to immediate Cause, Entail of January Cause (Disease or injury	ł	Due to (or a	s a conseq	uence of):									
	and I-tran	хап	that initiated events resulting in death) Last	c.	Due to (or a	s a consec	uence of):									
8760,	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	ical E			200 (0) (0)	3 4 0011364	donoe ory.									
387	phys the	edic		d.	_											
9 X	eath certific attending p for use as f	/Me	IF FEMALE:	23	c. If yes, outcom	e of pregna	ancv	- 55						04 D-164-15		
Вох	atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	Hiller	1 ☐ Live birth 4 ☐ Pregnant	2 Feta	Ideath 3□	Ectopic p					-	3d. Date of deligation (33d. Month)	-	ear
P. O.	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9☐ Unknown	at tarre or o	16a(ii J_	3 Other (S	Jecny)							
۳.	uires that the de signed by the a Id be detached f		Part II. Other significant cond	itions cont	nbuting to death	but not res	ulting in the ur	nderlying	ause give	n in Part I.		23e. Did tob	acco u	se contribute to	the cause of de	ath?
Records,	uires sign ld be	d by	Parkinson's	Disea	99							1 □ Ye	s 2[□No 3□Pro	bably 4 📆 J	nknown
Ö	w require been si should t	ete										24a. Was a		24h Word aut	oncu findings o	veilable
Ř	has ge 2	Completed										autops	У	prior to co	opsy findings a empletion of ca	use of
a	n: Th ficate or, pa	င္ပ	25. Was case referred to medi									1□ Yes 2		1 ☐ Yes	2□ No	
₹	Physicien: The lav this certificate has al director, page 2	00	examiner? 1 Yes 2 No	_	spital:		FD(0)		Othe	NET.		Check only on				-
Division of Vital	Phy r this aral d	5. T	27. Manner of Death		28a. Date of In (Month, D		ER/Outpatien 28b. Time of		JA	4 <u>K</u> Nul		d. Describe ho		Other (Spec	fy)	
O	ding I th. : After funer	후	1 StNatural 5 ☐ Pen 2 ☐ Accident inve	ding stigation	(Month, D	ay Year)	Injury	м	28c. Injury Work 1 ☐ \	(? Yes 2∐N			,,,,,,	,		
<u> S</u>	or Attending after death. I Director: After d in by the fune	fica	3 ☐ Suicide 6 ☐ Cou	-	28e. Place of I	njury - At he	ome, farm, stre	eet, factor	v. office		28	If. Location (St.	reet and	d Number or Rui	al Route Numb	er,
á	a the c	Certification;	4 Homicide dete	······································	building, e	itc." (Specif	y)		,			City or Town	, State)			
	Nespital or 124 hours after Funeral Dir 1616 in 1616 i		29a. Certifier 1 🔀 Certif	ying Physi	cian: To the bes	t of my kno	wledge, death	occurred	at the tim	e, date and	d place, an	d due to the ca	use(s)	and manner as	stated.	
		edicai	(Check only 2 Medic one)	ai Examin	er: On the basis and manners	of examina tated.	tion and/or inv	restigation	i, in my op	oinion, deat	th occurred	at the time, da	ate and	place, and due t	o the cause(s)	
	To the within To the comple	Σ	29b. Signature and title of cert	fier /	0	1		29	c. License			25		e signed (Month,		
)	1/		1 (1 Van	1/	lona	1	sur		D5	2261			Ap	ril 16,	2007	
			30. Name and address of person			death (Iten	1 23а) (Туре,	Print)								
			Alan R. Sega					cle,	Silv	er Sp	ring,	MD 209	906			
	Sta Registr		31. Date filed (Month, Day, Ye. APR 1		AND .	trar's Signa	ture	all s								
	1031011		HEN T	, Lucis	E STATE AND	E A		PERM								

		1000	1 - For State Registrar			aryland /		artment of I	Health and Death		Reg. No	has been been at	14389
	Physici	an	1. Decedent's Name (F	First, Middle, Las	t)					2. Date of D Month	Day		3. Time of Death
	/Medic		Kathleer							_	1 14,		11 PM
1	Examir	ier	4a. Facility Name (If no	7					or Location of Dear	th	4c.	County of Death	
			8552 New 5. Social Security Num			ge (In yrs. last b	irthday)	Newa1		8. Date of B	irth	Worcest	pplace (State or Foreign
	Funeral Director	į.	216-14-284 Usual Residence of De	14	_M 2 🛱 F	84	Yrs.	Months Days			7192	2 Mai	yland
	land ow			Ob. County		10c. City, Tox	wn or Lo	cation					10d. Inside City Limits
	Mary	ō	MD	Worces	ster	Newar	k						1 ☐Yes 2 ☐ No
	r 28a	rec	10e. Street and Number	er .		I		10f. Zip Code			10g. Cit	izen of What Cou	untry?
	h with	0	8552 New	ark Road	1			21	841			USA	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, tre Medical Examinal must be notified at ODGE.	Completed by Funeral Director	11. Marital Status 1 🙀 Never Married		12. Was Decedent Armed Forces? 1 Yes 25			Was Decedent of f Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	0-	14. Race - Amer Black, White Specify: Wh	, etc.
21215-0036	nours urai',	d b	3 Widowed 4 [Year or Dates:								
5-0	72 h	ete		 Decedent's Ed only highest grad 		168	. Dece (Give	dent's Usual Occu kind of work done	pation during most of wo ad)	rking	16b. K	ind of Business/li	ndustry
121	within no.	Ę	Elementary/Seconda	ary (0-12)	College (1-4or	5+)		gistered				Nursi	nα
2	filed within Hygiene. other than sent, It a M		17. Father's Name (Fin	st. Middle. Last)	4		1108	,100100	18. Mother's Na	me (First, Middi	e. Maiden		щь
Maryland	d be ontal	o Be	Frederic		rkor					an Mae]			
7	Me Me	2	19a. Informant's Name			19	b. Mailir	ng Address (Stree	t and Number or R				ip Code)
N S	od 2 s lith ar lith ar 27 is 17 is		Frederic	• • • • • • • • • • • • • • • • • • • •		. 1			11 Creek		ewark		1841
<u>6</u>	Hea Hea tem	1	20a. Method of Disposi		L (Broch			sition (Name of natory or other pla		Date	4	ocation - City or T	
Baltimore,	it. Pages rtment of rtant: If i njury or		12 Burial 2 □ C 14 □ Donation 5 [21. Signature of Funer	Other (Specify			n_Ce	emetery Name and Addr	Apri	1 17, 200	7 New	vark, MD	
Ba	Deparenti Deparenti Impo any ir		21. Signature of Furier	Few CLE	200		1000		=======================================	13 F	Grave	St Del	mar,DE 199
			23a. Part1. Enter the c shock, or leart fa		plications that caused use on each li	d the death. Do						. De De L	Approximate Interval Between
	Physician		Immediate Cause (Findisease or condition		. A.	SCUD							Onset and Death
	/Medical		resulting in death)		Due to (or as	a consequence	of):					1	10001
	Examiner		Sequentially list condit	tions	b								
	ν <i>≔</i>	iner	Sequentially list condit if any, leading to imme cause. Enter Underlyin Cause (Disease or inju- that initiated events	ediate ng	Due to (or as	a consequence	of):						
	ecute ind trans	Examiner	Cause (Disease or injuict that initiated events resulting in death) Las	iry	c								
68760,	icate be executed physician and s the burial-transit	al E	rooming in down, car		Due to (or as	a consequence	or):						
_	rtificate ng phy as the	Aedical	IE ECNAN E.									i i	
Box	seath certifica attending ph for use as the	an/h	IF FEMALE: 23b. Was decedent pr	egnant	23c. If yes, outcome 1☐Live birth	of pregnancy 2 Fetal deat	h 3[Ectopic pregnanc	CV .			23d. Date of deliv	
	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use at	Physician/M	in the past 12 mo 1 ☐ Yes 2 N		4□Pregnant a 9□ Unknown			Other (specify)	,			Month	Day Year
P.0	that the de ed by the detached	Phy	9 Unknown	-4 dist			to the			22a Did	4-6		the saves of death?
	res tha igned be del	by	Part II. Other significa	nt conditions of	ontributing to death t	out not resulting	in the u	nderlying cause gi	ven in Part I.				the cause of death? bably 4 Munknown
ord	w requir been si should	ted									165 2	140 2011	Dabiy 4 Bolikilowi
Records,	has b	Completed								24a. Wa aut	opsy	prior to c	opsy findings available ompletion of cause of
H	The	So								1 ☐ Yes	formed? 2 Z-No	death?	2 No
of Vital	i cian: Th certificate rector, pag	Be	25. Was case referred examiner?	-	Hospital:			0		ath (Check only	оле)		
of	Physical this dark	10	1 Xes 2 No 27. Manner of Death		28a. Date of Inju		utpatier Time o	I 3 DOA		dome 5 Res		6 □Other (Spec	ify)
	ding I	on	1 🗀 atural	5 Pending	(Month, Da	y Year)	Injury	Wo	ork?]Yes 2∐No	280. Describe	now injui	ly occurred	
Sic	Attending r death. ector: After by the fune	icat	2 Accident 3 Suicide	investigation 6 Could not be		iury - At homo	farm ct	eet, factory, office		28f Location	(Street an	d Number or Ru	ral Route Number,
Division	tal or Attendirs after death. al Director: Alled in by the fi	Certification:	4 Homicide	determined	building, e	tc. (Specify)	am, 50	eer, ractory, onice			own, State		ar node rumber,
	To the Hospital or Atlending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medicai			y sician : To the best liner: On the basis of and manner st	of examination a							
	vithin 2 To the complet	ž	29b. Signature and title	e of certifier				29c. Licen	se number			te signed (Month	
1			Inst.	The P.	White H	ml			0624	/	4	1-16-07	7
			30. Name and address	of person who d	completed cause of	death (Item 23a)	(Type,	Print)					
			DOROT	744 A.	HOLZ M	0 RTH. 1	7.0	20:	SNOW	ST. 51	1000 1	HILL, MD	21863
	Sta	ate	31. Date filed (Month,		32. Regist	rar's Signature						,,,,,,	
	Regist	rar	ΔF	PR 192	007 Rose	n K	1	made					
DH	MH 17 Rev 1/2	001			1		1	7					

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death		Reg. No 0 0	7 14390								
П	Physici	an	1. Decedent's Name (First, Middle, Lest)	2. Dete of Dee Month	Dey Ye	3. Time of Death								
1	/Medic		CLARENCE EDISON RIVERS	04-12	-2007	2:00 A.M.								
	Examin	er	4e Fecility Name (If not institution, give street end number) 4b. City, Town, or L	ocation of Death	4c. County of D	eath								
			417 PRITCHARD LANE Largo		Prince (
н	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Da	y, Year)	Birthplece (State or Foreign Country)								
	Director		577-42-4951 74 Trs. Usual Residence of Decedent	09-07-	1932 Pet	ersburg, VA								
	and *		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits								
	Many	ō	Maryland Prince George's Largo			1≰2 Yes 2 □ No								
	tha 28	5	10e. Street end Number 10f. Zip Code		10g. Citizen of What	Country?								
	3a o	Funeral Director	417 Pritchard Lane 20774		U.S.A.									
	death me 2	Jer	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispenic Origin? (Sp.	ecify Yes or No		merican Indian,								
0	aftar or h	Ē	1 ☐ Never Married 2日 Married 1型 Yes 2 ☐ No	Hican, etc.)	2000000	/hite, etc.								
8	Sur Sur Sur Sur Sur Sur Sur Sur Sur Sur	l by	3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates: 1953		Specify:	Black								
S S	72 h	Completed	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of work life. Do NOT use retired)	rina	16b. Kind of Busine	ess/Industry								
7	ithin	du	Elementary/Secondery (0-12) College (1-4or 5+)											
7	lad w lygiar ler th	S	12th Forensic Technician		Private I	ndustry								
and or	d off	æ	4.1 T		Maiden Surname)									
Ĕ	Jould J. Mar Jarke Jarke	ဥ	Clarence Charles Rivers	<u>-</u>	- 0: -	7.0.41								
Mai	d2 st h and raun		19a. Informant's Name/Relationship (Type, Print) Martha Rivers/wife 19b. Mailing Address (Street and Number or Rur 417 Pritchard Lane La											
e,	Haalt Haalt Her ther	ŀ		Date Date	20c. Location - City									
Baltimore, Maryland 21215-0020	agas or o		14 Burial 2 □ Cremation 3 □ Bernoval from State cemetery, crematory or other place)	04-19-07										
틀	it. Parturant		111711	J4-19-07	Chercen	IIdiii , I Id .								
Ba	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important if Heart Zile merked other than "neturel; or items 23a or 28e-f show any injury or other traumetic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility May Hedgman M01374 Cedar Hill FH 4111 F	PA Ave.	Suitland,	Md. 20746								
	12 500		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory ar	rest,	Approximate Interval Between								
4	Physician		Onset and Death											
A. C.	/Medical		Immediate Cause (Final disease or condition a Congestive Heart Failure											
	Examiner		resulting in death) Due to (or as a consequence of):											
	p is	ine	Sequentially list conditions, Due to (or es e consequence of):											
	and -trans	Хап												
68760,	The law requires that the death cartificate be executed attentions been signed by the attending physician and page 2 should be detached for use as the buriel-transit	Medicai Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	tery Disease										
87	cata physi tha		that initiated events resulting in death) Lest Due to (or as a consequence of):											
×	ding ding sa as	Š	d											
Box	as that tha death car ignad by tha attandir ba datachad for usa	Physiclan/												
P. O.	ha di tha chad	ysi	Part II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Part I.			ute to the cause of death?								
۳.	that t ad by data			101	/es 2.23°No 3.⊡	Probably 4 Unknown								
Records,	uiras Isign Idba	d by		24a. Was a	an autopsy 24	b. Were autopsy findings								
ខ្ល	v raquira bean siç should b	lete		perfo	med?	available prior to completion of cause								
ě	alaw has ga 2	Completed			21.	of death?								
ल			25. Was case referred to medical 26. Place of Deat		es 2.3110	1 ☐ Yes 2 ☐ No								
Division of Vital	- 5 5	o Be	examiner?		ne) ence 6 □Other <i>(S</i>									
Ö	Phy r this aral d	2	27. Manner of Death 28e. Date of Injury 28b. Time of 28c. Injury at		ow injury occurred	pecity)								
5	oding th: Afta fun	힅ㅣ	1 8 Natural 5 ☐ Pending (Month, Dey Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No											
<u>s</u>	Atten r daa ector by the	<u>≅</u>	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office			Rural Route Number,								
á	al or s afta l Dire	Certification:	4 ☐ Homicide building, etc. (Specify)	City or Tow	n, Siare)									
	To the Hospital or Attending Phys within 24 hours attendath. To the Funeral Director: After this completely filled in by the funeral di	Sal	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	end due to the o	ause(s) and manner	as stated.								
	he Hu in 24 he Fu platal	edical	(Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred and manner stated.	ed et the time, o	pate and place, and o	due to the cause(s)								
	Veith To the	Σ	29b. Signeture and title of certifier 29c. License number	2	29d. Date signed (Me	onth, Day, Yeer)								
-			Trem Chilles 555 Dufulus D28079		04-17-2007	7								
1	(10)		30. Name and address of person who completed cluse of death (Item 13a) (Type, Print)											
_	10/		FRANCINE A. HIGGS-SHIPMAN, MD 9200 Basil Court Suite	200 Lar	go, Md. 2	0744								
	Stat Registra		31. Dete filed (Month, Day, Yeer) ADD 1 Q 2007											

DHMH 16 Rev 6/95

			1 - For State Registrar	State of M	arylan				ealth a Death	and M		giene ()	07	14391
	Physici		Decedent's Name (First, Middle, Las DORA	LEE		RAY					2. Date of Dea	14 ^{Day} 20	0 Ž ^{ear}	3. Time of Death 6:24Pm
	/Medio Examir		4a. Facility Name (If not institution, give CLINTON NURSING					Town, or	Location o	ol Death			y ol Death CE GE	EORGE'S
	Funeral Director		3/6-30-246/	x 7. Ag □M 2ጪF	69	last birthday) Yrs.	If Unde Months	r 1 Year Days	II Under Hours	24 Hrs. Min.	8. Date of Birt APRIL 2	⁷ 1938	COL	place (State or Foreigr Intry) ginia
	ne Maryland Ba-f ehow	Director	Usual Residence of Decedent 10a. State 10b. County MD PRINCE (GEORGE'S	10c. Cit	y, Town or Lo	INER							10d. Inside City Limits 1 XYes 2 ☐ No
	th with the 23a or 2		10e. Street and Number 4300 RUSSELL STRI	EET # 2			10f. Zip	20712				10g. Citizen of		intry?
036	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show dital Exarta ne must be conflied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		1	Was Dece f Yes, spe 1 ☐ Yes	cify Cuba	spanic Ori n, Mexicar Specify:	gin? (Spe i, Puerto l	cify Yes or No- Rican, etc.)		ck, White	ican Indian, , etc. BLACK
Baltimore, Maryland 21215-0036	l within liene.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th	ucation de <i>completed)</i> College (1-4or :	5+)	(Give	dent's Usual Occupation kind of work done during most of workin OO NOT use retired) CASHIER			16b. Kind of PRIV		Business/Industry		
yland	be file ital Hyg id othe event,	To Be C	17. Father's Name (First, Middle, Last) GREENWOOD TAYLOI	_		18. Mother EVEL				LYN	(First, Middle, THOMAS		den Sumame)	
re, Mai	1 and tealth im 27 iner tr		19a. Informant's Name/Relationship (TEVERETT L. RAY/SO) 20a. Method of Disposition	ON	20b. P		ANG(ORA D	RIVE	CHEI	TENHAM		AND 2	20623
ltimo	t. Page rtment rtant: Il		1 🔀 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licenses)			LINGTON	NAT	IONA	L 5	/2/2	007 B. JEN			IRGINIA
Ba	permi Depa Impo any Ir		1 K.D.M-	hall		7	474	LANDO	OVER	ROAD	LANDOV	ER,MARY		
	Physician /Medical		23a. Part1. Enter the disease, of comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aCORON	ARY A	ARTERY			, such as	cardiac o	r respiratory ari	rest,		Approximate Interval Between Onset and Death
ķ	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. END STAGE RENAL DISEASE Due to (or as a consequence of):										
8760,	ate be executed hysician and the burial-transit	dicai Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. DIABETES MELLITUS Due to (or as a consequence of): ATRIAL FIBRILLATION										
.O. Box 68	death certific e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐										ate of delive	ery Day Year
٣	w requires that the been signed by th should be detache	by	Part II. Other significant conditions co	ntributing to death b	ut not resi	ulting in the ur	nderlying o	ause give	n in Part I.			bacco use con		he cause of death?
Vital Records	The law ate hes b page 2 sl	Completed						-			24a. Was a autop perfor	med?	prior to co death?	opsy findings available ompletion of cause of 2 No
Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes = 2 ☒ No	Hospital: 1 ☐ Inpatie	t 3□ DC	26. Place of Death Check or				conly one 6 □Other (Specify)				
Division of	ding h. After fune		27. Manner of Death 1 ⊠ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury			2	28d. Describe how injury occurred			,,,	
Divis	F the C	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								281. Location (Street and Number or Rural Route Number, City or Town, State)			
	the Hospital of hin 24 hours of the Funeral D upletely filled in	edicai	29a. Certifier 1 ★ Certifying Phy (Check only one)	sician: To the best ner: On the basis o and manner st	f examinat	wledge, death tion and/or inv	occurred restigation	at the tim , in my op	e, date and inion, deat	d place, a th occurre	nd due to the o d at the time, o	ause(s) and m late and place,	anner as s and due t	stated. o the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier	Ö		n-	290	c. License			2	9d. Date signe	d (Month,	Day, Year)
)	8		30. Name and address of person who co						D8172			APRI		, 2007
/	Sta		Khosrow Davachi 31. Date filed (Month, Day, Year) APR 1 9 200		28 S	Souther	n Av	enue	SE #	310	Washin	gton, I	C 20	032

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 17, 2007 **Physician** 5:22 A M APRIL STEPHEN M. ROSSEN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY SUBURBAN HOSPITAL **BETHESDA** 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1**X** M 2 □ F 67 Yrs. JUNE 14, 1939 CALIFORNIA Director 098-32-5261 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No **BETHESDA** MONTGOMERY Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20815 U.S.A. 7111 WOODMONT AVENUE #606 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 □X'es 2□No
If Yes, Give
Year or Dates: 1964 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1964 1966 WHITE 1 ☐ Yes 2 No Specify. Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) WRITER **EDUCATION** 5+ permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any Injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROBERT ROSSEN SUSAN SIEGEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7111 WOODMONT AVENUE, #606, BETHESDA, MD 20815 SUSAN S. KO-WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place)
WEST CHESTER HILLS Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 04/19/2007 TERRY TOWN, NY 4 □ Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND CHARTER 20852 Approximate Interval Between Onset and Death 23a. Part1. Enter the dise = 9 an omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 3 yrs netastatic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examiner Due to (or as a consequence of): requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 1√0 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed 1□ Yes 2 No Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury or Attending 1 Natural 5 Pending investigation Japital o. 4 hours after dea. •ral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours aff

To the Funeral D

completely filled in VC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 02277 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Barr 5454 Wisconsundre Cherr Chascimo 20815 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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Baltimore, Maryland 21215-0036

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Records,

Vital

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Division

				State of Marylan	•	te of Death		000-	11.002
			Decedent's Name (First, Middle, Last)		Certifica	le of Death	2. Date of Death		3. Time of Death
	Physici	an	Janio	G SI	nnor		ADO(1)	Day Yea	07 (0:05P
	/Medic Examin		4a Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death	4c. County of De	eath
			12648 Cour	rcil Oak	Drive	Walc	ort	Cha	rles
	Funeral		5. Social Security Number 6. Sex	M 200 F	Ast birthday) ff Under Months	er 1 Year If Under 24 Hrs Days Hours Min	(Month, Day,	(ear) 9. E	Birthplace (State or Foreign Country)
	Director	-	579284973 Usual Residence of Decedent	7	7 113.		06-25	5-1912	G14
	Jend Mend		10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
	Mar.	혅	VA		lexano	Iria			1 X Yes 2 □ No
	章 P 2 2 4 2 2 4 4 2 4 4 4 4 4 4 4 4 4 4 4	흠	10e. Street and Number	0.1	10f. Z	ip Code	10	g. Citizen of What	Country?
	ath w	Funeral Director	1610 SUHE	er Stree	t c	6314 double 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Consider Von er No	USF-	merican Indian,
	er de	Š	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☑ No	ff Yes, sp	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer	to Rican, etc.)	Black, W	
22	illed within 72 hours after death with the Marylend Hyglene. ther than "naturel", or heme 23e or 28e-f ehow ent, the Medical Examinar must be notified at	2	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2. No Specify:		Specify:	Black
21215-0020	72 ho	Be Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Decedent's Us	ual Occupation ork done during most of wo	orking	6b. Kind of Busine	ss/Industry
2	ig e	햩	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. DO NOT	use retired)	(a Cal	A)cic
7	Hed w Hygler Sthert ent, th	8	17. Father's Name (First, Middle, Last)		Coon	18. Mother's Na	me (First, Middle, M	aiden Surname)	crita
ä	Mental Parked of	8	lenton G	reen Sr		Fliza	heth	111540	
Maryland	E P E E	٤	19a. Informant's Name/Relationship (Ty)	pe, Print) Carand	19b. Mailing Addres	ss (Street and Number or F	ural Route Number,	City or Town, State	e, Zip Code)
	1 and 2 Haalth a em 27 le other tree	- 1	Kisha Colema	n-Daughter	13648C	ouncel ca	K Dr. W	aidorf	MD 20601
more,	of Ten		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	20b. P	lace of Disposition (Nametery, crematory or	ame of other place)	Date 2	Oc. Location - City	or Town, State
<u>E</u>	ment of tant: If Its		4 ☐ Donation 5 ☐ Other (Specify)	B	ethel (emetery	4-19-07 F	lexan	Iria VA
Balt	permit. Pages Department of Important: If II eny Injury or page.		21. Signature of Funeral Service License	° 1/	22. Name a	and Address of Facility C	reenef	unera	u Home
	2020-		23a. Part1. Enter the disease, or compli		1814	-ranklins	t. Alexa	ndria,	VA 22314 Approximate
-	Dhusiaian		shock, or heart failure. List only on	e cause on each line.	i. Do not enter the int	de or dying, such as cardia	o or respiratory arro-	,	Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final	LUNG CANCE				i	
	Examiner		disease or condition resulting in death)		r as a consequence of):			
	₽ #	edical Examiner	_ h						
	ficate be executed g physician and as the burial-transit	Wax	Sequentially list conditions, if any, leading to immediate	Due to (or):				
68760,	be es		cause. Enter Underlying Cause (Disease or injury that initiated events				-		
	ficate p phy as the		resulting in death) Last	Due to (or	as a consequence of				
BOX	es that the death certifigned by the ettending be detached for usa a	Physician/M	d						
B	he deat	100	Part II. Other significant conditions con	tributing to death but not resu	ulting in the underlying	cause given in Part f.	23b. Did tob	acco use contrib	ute to the cause of death?
О	d by t		Hypertension				1 □ Ye	8 2□No 3□	Probably 4 Unknown
Division of Vital Records,	Attending Physician: The law requires that the rideath. setor: After this certificate has been signed by the by the funeral director, page 2 should be detached.	Ď	0.7.0				24a. Was an	autopsv 24	b. Were autopsy findings
င္ပဲ	w require been signification	Completed	Colon Cancer				perform		available prior to completion of cause of death?
Ě	he lav	E					1 ☐ Yes	2 No	1 ☐ Yes 2 No
Œ	an: T	Be C	25. Was case referred to medical			26. Place of De	eath (Check only one)	
<u>></u>	sysici ils ce	2	examiner?	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ [Home 5□ Resider	nce 6XiOther (S	Specify Home
Ē	Mer th	Ë	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	w injury occurred	
8	tend death ttor: A	Cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho			28f. Location (Stre	eet and Number or	r Rural Route Number,
	2 4 5 C	ortif	4 ☐ Homicide determined	building, etc. (Specif)	()	, onioo	City or Town,		
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical Certification:	29a. Certifier 1□ Certifying Phys	ician: To the best of my know	wledge, death occurre	d at the time, date and place	e, and due to the car	use(s) and manne	r as stated.
	he Ho In 24 he Fu	odic	(Check only 2 Medical Examinate)	er: On the basis of examinet and manner stated.					
	1 4 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Σ	29b. Signature and title of certifier	c11 1	1	9c. License number		d. Date signed (M	
	(a)		1/5	IVa -		0101030692		04-16-	-0 /
0	[3]		30. Name and eddress of person who co			ME WA T	7314		
_	Sta	te		32. Registrar's Signa	17.71.60	ME, V4. 22			
	Registr	0.5	31. Date filed (Month, Day Year)	Fig 1. 1. 1	Johnson				

DHMH 16 Rev 6/95

			For State Registrar	State	of Mary	land / Depa <i>Cei</i>	artment of tificate o				ienę _{9g. Nó.} - U		14394		
	Decedent's Name (First, Middle, Last) Deate of Deate										Vace	3. Time of Death			
	Physici /Medio		MILDR	·			APRIL	13, 20	0°07	11:30AM					
	Examir		4a. Facility Name (If not institutio	-			4b. City, Town				4c. County				
			Holy Cross 5. Social Security Number	HOSPITA 6. Sex		yrs. last birthday)	If Under 1 Ye	er Spr	r 24 Hrs.	8. Date of Birth	MON				
П	Funeral Director		214-32-8210	1□M 2√2F			Months Da			June 9	Year) 1925	9. Birting Coul Ma	place (State or Foreign htry) ryland		
	ט		Usual Residence of Decedent							3 4110 3	, _ , _ ,				
	arylar show	_	MD MO	, ntgomer		City, Town or Lo	cation lver S	Sprine	T.			1	0d. Inside City Limits 1 ☐ Yes ※☐ No		
	the M	Director	10e. Street and Number				10f. Zip Cod		<i></i>	14	0g. Citizen of W	hat Caus			
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show styl injury or other traumatic event, the Modical Exaction of the modified at ance.	ai Dir	15811 Radw	ick La	ne			0906			_	S.A	-		
	ems and	Funeral	11. Marital Status	12. Was De	cedent Ever Forces?		Was Decedent	of Hispanic O	rigin? (Spe	ecify Yes or No- Rican, etc.)		- Americ	ean Indian,		
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Mar 3 ② Widowed 4 ☐ Divorced	ned 1 Tyes	s 2⊠No Give		I□Yes 2 2 71			,	1	в1			
8	tural	ed b		Year or	Dates:	16a, Dece	ient's Usual Oc	cupation			16b. Kind of Bu	siness/In	dustry		
215	hin 72	piet	(Specify only higher Elementary/Secondary (0-12)	st grade complete	d) (1-4or 5+)	(Give	kind of work do DO NOT use re	ne durina mo	st of work	ing					
2	er tha	Completed	12th		(1 401 31)		Homema					Iome			
Maryland 21215-0036	ould be filed v Mental Hygie karked other i latic event, ID	Be	17. Father's Name (First, Middle, Richard H.	*				18. Moth		e <i>(First, Middle, N</i> rie Wis		e)			
2	should and Men marke	၉	19a. Informant's Name/Relations			19h Mailin	on Address (Str	and Numb		I Route Number,		State Zin	Codel		
	and 2 seelth an n 27 ia ner trau		Erik J. Smi		andso		_			rcle, C	•				
ē,	s 1 ar		20a. Method of Disposition		26	Db. Place of Dispo	sition (Name of				20c. Location - 0				
altimore,	Pages nent of in ant: if its		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		m State				4/2	1/07 s	ilver	Spr	ing, MD		
<u> </u>	Depertriments imports any injustrations.		21. Signature Funeral Service	Licenser									ME, P.A.		
8	20229		Denge	1 sus	enex							lle,	MD 20850		
П			23a. Part 1. Enter the disease, o shock, or heart failure. List	r complications that t only one cause or	t caused the n each line.	death. W o not ent	er the mode of	dying, such as	s cardiac o	or respiratory arre	est,		Approximate fnterval Between Onset and Death		
Sec.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			ant Bra	in Tun	or							
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	leath certifi attending I for use as	ician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pr						23d. Date	of delive	NO.		
. Box	at the death by the atte	icia	in the past 12 months?	4□ Pre	e birth 2 🗌 gnant at time		Ectopic pregna Other (specify				Mon		Day Year		
P.O.	at the by th	by Phys	9 Unknown	9□ Unl											
	as the gned		Part II. Other significant conditi	ons contributing to	death but no	t resulting in the ur	nderlying cause	given in Part	I.		tobacco use contribute to the cause of death?				
9	w require been signature	eted		-							ably 4 Unknown				
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_		e Co	25. Was case referred to medica	u			-	00 Di-		1□ Yes 2	No 1	Yes	2 No		
	ysiclan: is certific director,	To B	examiner?	Hospital:	npatient	2 ER/Outpatien	t 3 DOA	Cthor		n <i>(Check only one</i> me 5 ☐ Resider		r (Specifi	<i>(</i>)		
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<u> </u>	eath. or: Af the fu	catic		igation				☐Yes 2☐]No						
Division of	for At after d Direct	Certification:	4 Homicide determ	nined 286. Pla	ce of Injury - Iding, etc. (S)	At home, farm, stro oecify)	eet, factory, offi	СӨ	1	28f. Location (Str City or Town,	eet and Numbe , State)	r or Rura	l Route Number,		
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:		29a. Certifier 1 Certifyii (Check only 2 Medical	ng Physician: To t	he best of my	knowledge, death	occurred at the	e time, date a	nd place, a	and due to the ca	use(s) and mar	ner as si	ated.		
	the H hin 24 the F hplete	Medicai	one)	and ma	anner stated.				am occum						
	To To	-2	29b. Signature and tittle of centifie	MIND "	N		29c. Lice	ense number D507	791	29	od. Date signed 4/16/		Day, Year)		
ř	5		30. Name and address of person	Who consists of	The state of the s	(Item 22a) (Time	Print)								
			Damirez Fos	//	.D.			Park	Dr.	, Silve	r Spri	ing,	MD 20902		
	Sta		31. Date filed (Month, Day, Year,) 32	egistrar's S		0. R								
	Registr	ar	APR 19	2007	MURI	15 16									

			- State Registrar			Ce	rtifica	te of L	Death		R	eg. No.	UUI	11000	
		27	1. Decedent's Name (First, Middle, Las					2	2. Date of Deat Month	3. Time of Death					
н	Physici		BASYA SHADEVICHENE								Day Year 7.24 P. M				
To the second	/Medic		4a. Facility Name (If not institution, give street and number)					APRIL 16, 2007 7:34 4b. City, Town, or Location of Death 4c. County of Death							
	Examin	ICI	SUBURBAN HOSPI		,		PERMIT OF A								
-	Funeral		5. Social Security Number 6. S		7. Age (In yrs	s. last birthday)	If Unde	r 1 Year	HESDA If Under		B. Date of Birth		9. Birth	NTGOMERY nplace (State or Foreign	
т	Funeral Director			□M 21X F	86		Months	Days	Hours	Min.	(Month, Day, 03/20/1	Year)	Cou	untry)	
	Director		Usual Residence of Decedent				l)J/2U/I	741		UKRAINE	
	land t		10a. State 10b. County		10c. C	City, Town or Lo	cation							10d. Inside City Limits	
	Aary f sho ed a	ō	MARYLAND MONTGO	ALDA.			T) (\01217T						1 XYes 2 No	
	the N	Director	10e. Street and Number	TEKI				OCKVI	<u> </u>		1	On Citiz	en of What Cou	untru?	
	with the Maryland a or 28a-f show t be notified at		5801 NICHOLSON LAI	NF #017			101.2		20852	,	'	og. Omz	U.S.A.		
	ath v	Funeral				110									
	tems term	l an	11. Marital Status	Armed Fo		U.S. 13.	If Yes, sp	ecify Cuba	ispanic Ori an, Mexicar	gin? (Speci 1, Puerto Ri	ify Yes or No- ican, etc.)	'	 Race - Amer Black, White 		
36	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notified at	Z T	1 Never Married 2 Married	1 ☐ Yes If Yes, Giv	/e		1 ☐ Yes	2 No	Specify:				Specify: [J	HITE	
Ö	iral' Exa	d by	3 ★Widowed 4 Divorced	Year or D	ates:										
5	d within 72 ho giene. r than "natu the Medical	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)		16a. Dece	dent's Us kind of w	ual Occup ork done d	ation <i>Juring mos</i> i	t of working	,	16b. Kin	d of Business/li	ndustry	
21	c - o	Įd.	Elementary/Secondary (0-12)	College (1	I-4or 5+)										
2	filed withii Hygiene. Ither than	ပ္ပြဲ		4			OFFI	CE MA	NAGER				GOVERN	MENT	
p		Be	17. Father's Name (First, Middle, Last,)				-		,	First, Middle, I		Surname)		
<u>a</u>		户	HIRSCH ZAVITS						SOP	HIA "	UNKNOW	N''			
Maryland 21215-0036	i i i i		19a. Informant's Name/Relationship (Type. Print)		19b. Maili	ng Addres	s (Street a	and Numbe	er or Rural i	Route Number	r, City or	Town, State, Z	ip Code)	
			SOPHIA ROZAS, DAUG	HTER		5629	AT.TA	VIST	A ROA	D. BF	THESDA	МΛ	RYLAND	20817	
ā,	一工市を		20a. Method of Disposition	, <u>.</u>	20b.	Place of Dispo	osition (Na	me of	-1 1021	Da	te	20c. Loc	ation - City or T	Fown, State	
0			1 ☑ Burial 2 ☐ Cremation 3 ☐		State				1	/ /10 /	0007				
Baltimore,	# 돌라를		4 ☐ Donation 5 ☐ Other (Specif		JU	JDEAN M	2 Name a	AL G	DNS U	4/19/	2007 ()LNE	Y, MARY	LAND	
Ba	permi Depar Impor any Ir		Land Service Lice	1300		E	DWARI	SĂĞ	ĔĽ FÜ	ŇERAL	DIRECT	rion	, INC.		
						+10	191 F	OCKV	ILLE	PIKE.	ROCKV	ILLE	, MARYL	AND 20852	
п	Physician /Medical Examiner		23a. Part1. Ent the dise e, or com shock, or heart failure. List only	one cause on e	aused the dea	ath. Do not en	ter the mo	ав от аутп	g, such as	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death	
			Immediate Cause (Final disease or condition VENTRILULAR FIBRILLATION										Short and Boddin		
			resulting in death) Due to (or as a consequence of):												
			Immediate Cause (Final disease or condition resulting in death) a. VENTRICULAR FIBRILLATION Due to (or as a consequence of): B. HYPRICALIEMIA												
	EMERICAL STREET	ner	Sequentially list conditions, if any, leading to minediate cause. Enter Underlying									-			
	be executed sician and burial-transit	Examiner	that initiated events	z M	4483										
ó	exe an ar rial-t	Ж													
68760,	certificate be executed iding physician and ise as the burial-transit	//Medical	d												
9	ificate l g physias the b	edi										-			
č		1	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	tcome pf preg pirth 2 □ Fe							2	3d. Date of deli-	very	
m	atter atter	cia	in the past 12 months?	_Ectopic _Other (s	pregnancy specify)					Month	Day Year				
O.	the cy the chec	Physicia	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)												
Δ	he law r quires that the death the has been signed by the atter age 2 shruld be detached for u		Part II. Other significant conditions	contributing to de	eath but not re	esulting in the u	ınderlying	cause give	en in Part I.		23e. Did tol	bacco us	e contribute to	the cause of death?	
ds	sign d be	by									1 □ Ye	es 2	Mo 3□Pro	obably 4 □Unknown	
Ö	w r quir been si sh uld b	Completed								_					
ec	law lask	du									24a. Was a autops	sy	prior to c	topsy findings available completion of cause of	
<u> </u>		Ö									perform	med? 2 □ No	death? 1 ☐ Yes	21 No	
'ita	ilan: The	Be (25. Was case referred to medical examiner?						26. Place	of Death (Check only on	e)			
or Vital Records,	nysich nis cer direct	To	1 Yes 2 No	Hospital: 12	Inpatient 2[☐ ER/Outpatie	nt 3 🗆 🗅	OA Oth	er: 4 □ Nu	rsing Home	e 5 🗆 Reside	ence 6	□Other (Spec	cify)	
0	Hospital or Attending Physician: 14 hours after death. Funeral Director: After this certific tely filled in by the funeral director,		27. Manner of Death	28a. Date		28b. Time o	of	28c. Injun Worl	y at	28	d. Describe ho	ow injury	occurred		
Division	nding th.	it o	27. Manng-or Death 27. Manng-or Death 28d. Describe how injury occurred 28d. Describe how injury occ												
/is	Attend r death. ector: /	Ę	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	200. Flace	of injury - At	home, farm, st	reet, facto	ry, office		28	f. Location (St	reet and	Number or Ru	ıral Route Number,	
ă	afte afte Dir	erti	4 I Horniciae	build	ng, etc. (Spec	city)					City or Tòwi	n, State)			
	spita lours nera / fille		29a. Certifier Certifying Pt	ysician: To the	best of my kr	nowledge, deal	th occurre	d at the tir	ne, date an	nd place, an	nd due to the c	ause(s)	and manner as	stated.	
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: / completely filled in by the fi	Medical	(Check only 2 Medical Examone)	niner: On the b	asis of examin	nation and/or in	rvestigatio	n,∙in my o	pinion, dea	ath occurred	d at the time, d	late and	place, and due	to the cause(s)	
29c. License number								9d. Date	signed (Month	n, Day, Year)					
	F S F Ö	m Brino Dog 57124													
	V					~ -	B	0	0)	1129	7		1/17/	0 /	
			30. Name and address of person who					n b	141	0	1:	-	1050		
			31. Date filed (Month, Day, Year)		egistrar's Sign	cal Cent	5 1	11 0	<i>γ</i> ΟΙ	rock	ulle, m	00	0850		
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4)16107 1934 PM

SHADEVICHENE

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 VIVAINLO /Medical 4b. City, Town, or Location of Death 4a. Facility Name (In ot institution, give street and number) 4c. County of Death **Examiner** Washington 9. Birthplace (State or Foreign Country) Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕱 F 80 May 30 1926 Director 212-22-1928 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 10830 Brentwood Terrace 21740 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No þ Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Clerk</u> Public School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ۵ Andrew Brode Jane Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn E. Stanley Jr. - Son <u>11715 Robinwood Drive, Hagerstown, Md. 21742</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 4/24/07 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home soll M Unne 415 E. Wilson Blvd. Hagerstown, Md. 21740 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnemoma **Physician** 24 has hilobar /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, the within 24 hours after death.

To the Funeral Director: Al

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment.

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

aftending physician and for use as the burial-tran After this certificate has been signed by funeral director, page 2 should be detact

State Registrar

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

and manner stated.

29c. License number D28365

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

4-19-07

Hagustonen MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANZA R DSHAFI

368 mill.

32. egistrar's Signature APR 23 2007

			Type or Print in State of Maryla				N.I.	E U U	7 1439
	,	1 - For State Registrar	,		ertificate of			leg. No.	
		1. Decedent's Name (First, Middle, Las	it)				2. Date of Dea Month	th Day Year	3. Time of Death
Physicia /Medic		Rachael Lucille	Scott					1, 2007	8:12P ^M
Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death		4c. County of Deat	th
		5425 Schoolhous			Marbur		8. Date of Birth	Charles	balana (Chata as Familia
Funeral Director		5. Social Security Number 6. Si 223-08-8821 1	ex	rs. last birthda Yrs.	Months Days	Hours Min.	Sept. 2	, Year) Co	hplace (State or Foreign untry) irginia
land ow		10a. State 10b. County	10c.	City, Town or	Location				10d. Inside City Limits
Mary -f sh	ţ	Maryland Charles		Marbury	7				1 ∐Yes 2 X No
r 28a	Director	10e. Street and Number		141041	10f. Zip Code			log. Citizen of What Co	ountry?
h with		5425 Schoolhous	e Road		20658			U.S.A.	
ems ems	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	1 U.S. 1	 Was Decedent of If Yes, specify Cult 	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Inportant: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	1		1 □ Yes 2 🔯 No	Specify:		Specify: Wh	
72 h	Completed	15. Decedent's Ed (Specify only highest gra		(G)	cedent's Usual Occu ive kind of work done e. DO NOT use retire	during most of work	ring	16b. Kind of Business/	'Industry
within than the Me	d m	Elementary/Secondary (0-12)	College (1-4or 5+)		memaker	90)		Her Home	
Hygir Hygir ther		17. Father's Name (First, Middle, Last)		IR	memaker	18. Mother's Name	e (First, Middle,	Maiden Surname)	
id be ental ked o	To Be	Hugh Warden Krat	zer			Merdie	Catheri	ne Fauls	
shoul Mind Mind Mind Mind Mind	-	19a. Informant's Name/Relationship (19b. Ma	ailing Address (Stree	t and Number or Rui	ral Route Numbe	r, City or Town, State, 2	Zip Code)
alth a alth a 27 is sr tra		Cathy Berry / Da	ughter	PO E	3ox 508 M	Marbury, M	aryland	20658	
of He rothe		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □		b. Place of Dis cemetery, o	sposition (Name of crematory or other pla	ace)	Date	20c. Location - City or	Town, State
Page ment ant: II		4 Donation 5 Other (Specify		nville	U C C Ce	metery 4/19	9/0/	Lynville,	Virginia
permit. Departi		21. Signature of Funeral Service Licer		0668	22. Name and Addr Williams 4270 Hawt		Ome P.A	A in Head, Ma	ryland 2064
d.		23a. Part1. Enter the disease, or com shock, or heart allure. List only	plications that caused the done cause on each line.	eath. Do not	enter the mode of dy	ing, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Emphysema						Onset and Death years
/Medical		resulting in death)	Due to (or as a cons	sequence of):					
Examiner		Sequentially list conditions,	b						
sit ad	xaminer	if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	sequence of):					
xecuted and al-transit	хап	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a cons	sequence of):					
be eg ician buria	a E			,					
ficate ficate physics the	edic		_d						
eath certificate be executed attending physician and for use as the burial-transit	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pre	gnancy	• De			23d. Date of de	livery
The law requires that the death certificate be also been signed by the attending physicia page 2 should be detached for use as the bur	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live birth 2□F 4□Pregnant at time o 9□Unknown		3 □Ectopic pregnan 5 □ Other (specify)			Month	Day Year
that s that ned b		Part II. Other significant conditions	contributing to death but not	resulting in the	e underlying cause g	iven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
requires een sign	d by	_ Diabetes Mellitu	s, Obesity,				1 □ Y	′es 2□No 3□P	robably 4X Unknown
aw re	olete	Congestive Heart	Failure				24a. Was a		utopsy findings available
The latte ha	Completed						autop perfor 1□ Yes	rmed? death?	completion of cause of 2 □ No
	Be C	25. Was case referred to medical				26. Place of Dear			
hysic nis ce direc	To B	examiner? 1 ☐ Yes 2 █ No	Hospital: 1 ☐ Inpatient 2	2 ☐ ER/Outpa	TIGHT OF DOX			lence 6 □Other (Spe	ecify)
or Attending Physician: ter death. irector: After this certific. n by the funeral director,	tification:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year	28b. Tim Injui	ry W	ury at ork? ⊒Yes 2 □No	28d. Describe h	ow injury occurred	
r Atter ter dea irector	Tifica	3 Suicide 6 Could not be determined	28e. Place of injury - A building, etc. (Sp	it home, farm, ecify)	street, factory, office	9	28f. Location (S City or Tow	Street and Number or R vn, State)	ural Route Number,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D0061616

April 12, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11350 Pembrooke Square
32. F Sistrar's Signature Waldorf, Maryland R. Sindhwani, MD

31. Date filed (Month

Medical

State Registrar

		•	For State Registrar	State of Ma	aryland / Depa <i>Cel</i>	artment of F rtificate of			Glene U	J 1	14330
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	CLARENCE JUNIOR S			45 03 Tours	a Lagartina of Dageth	APRIL	15,	2007 y of Death	11:45 A M
Н	Examin	er	4a. Fecility Name (If not institution, give MARINER HEALTH OF		LAUREI.	LAU	r Location of Death REI .				ORGES
H	Funeral		5. Social Security Number 6. Sec	9x 7. Ag	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da			place (State or Foreign
Н	Director		227-12-4230	MM 2□F	86 Yrs.	Months Days	Hours Min.	JUNE 1	2,1920	VIRG	ÍNIA
	and w	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
	Mary -1 ehc	ğ	MARYLAND PRINCE G	EORGES	CAPITAL H	ETGHTS					1 ☐ Yes 2 ☐ No
	h the or 28a e notii	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
	ath wi	rai	6323 CARRINGTON C			207			UNITEL		
Maryland 21215-0036	a within 72 hours after death with the Maryland jiene. r then "naturel", or Iteme 23a or 28a-f ehow Ite Medicel Evacuter must be rediffed at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:	No.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	Speci	ce - Americ ack, White, ify: BLA	etc.
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	dent's Usual Occup	oation during most of world)	king	16b. Kind of I	Business/Inc	dustry COLUMBIA
121	within ene. then "	Completed	Elementary/Secondary (0-12) 3RD GRADE	College (1-4or	5+)	DO NOT use retired DIAL ENG			GOVERN		COLOUDIA
d 2	be filed v ital Hygie id other t		17. Father's Name (First, Middle, Last)			DIAL ENG	18. Mother's Nam	ne (First, Middle	1		
lan	ld be enta	To Be	HARVEY E. STEWART				BESSIE F	AGE STE	WART		
ary	d 2 should th and Men 7 Is marke traumatic		19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailie	ng Address (Street	and Number or Ru	ral Route Numb	er, City or Town	, State, Zip	Code) 20785
	s 1 and 3 if Health item 27 other tra		ANTOINETTE A. WHI	TE / DAUGI			HILLS, TE				
Baltimore,	Pages nent of ant: If it ury or c		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	"	ST. JOSEPH'	S CHURCH C	M. APRIL	the second secon	20c. Location	, MAR	
Bal	permit. Par Departmen Importent: eny injury		21. Signature of Funeral Service	JOHNSON MO	0583 Î	XYOA TITATIAP	ss of Facility VERAL HOME, STON ROAD,	TUDIAN HE	AD, MARYI	AND 2	0640
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complete shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Due to (or as	d the death. Do not entered not be consequence of):	er the mode of dyli	ng, such as cardiac	or respiratory a	irrest,		Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed ten as been signed by the attending physician and page 2 should be detached for use as the buriat-transit	edicai Examiner	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence of):						
.O. Box	at the death certific by the attending p itached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal death 3	⊒Ectopic pregnanc ☐ Other (specify) _	y			ate of delive	ery Day Year
rds, P.	quires that n signed t uld be det		Part II. Other significant conditions o	ontributing to death b	_		ven in Part I.		tobacco use cor Yes 2 □ No	ntribute to th	he cause of death? pably 4 Munknown
Vital Records,	The law require ate has been sip page 2 should b	Completed by						24a. Was auto perfo 1 - Yes		prior to con death?	psy findings available mpletion of cause of
/ita	Physicien: The this certificate har all director, page	Be	25. Was case referred to medical examiner?			la	26. Place of Dea	th (Check only	one)		
of/	Physi this c al dire	은	1 Yes 2 No	Hospital: 1 Inpatie	10.77		4 Nursing H		idence 6 00 how injury occu		(ע
ou	ding l h. After funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year) Injury	Wor	rk? Yes 2 □ No	20d. Describe	now injury occu		
Division of	To the Hospital or Attending i within 24 hours after death. To the Funerel Director: Atter completely filled in by the funer	Certification;	3 Suicide 6 Could not be determined	28e. Place of In	jury - At home, farm, st c. (Specify)	reet, factory, office			(Street and Νυπ wn, State)	ber or Rura	al Route Number,
	e Hospital or 124 hours afte e Funerel Dir letely filled in I	Medical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	of my knowledge, deat of examination and/or in ated.	h occurred at the til vestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and n date and place	nanner as si , and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	All D	. 4	29c. Licens	se number		29d. Date sign	ed (Month,	
				7100	~ NIY	7 70	024.19	-1	Hord	(1)=	2007
(182		30. Name and address of person who SYES SASIE	14333	Laurel	BOWIE	FORD	St 208	LAU	UZL	MD 20708
	Sta Registi	_	31. Date filed (Month, Day, Year) APR 1 9	2007 32. Gegisti	rar's Signature	neck					

			1 - For State Registrar	State of Maryla		artment o				Reg. N	200	7	14399
	Physici		Decedent's Name (First, Middle, Las Robert Shr:						2. Date of De Month	D	ay Ye	ar	3. Time of Death a
à.	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town	n, or Location	of Death	April	- · T	2007 c. County of D	eath	9:04 M
	*		414 Pine Bluff Roa			Salis					Wicon		
3	Funeral Director		5. Social Security Number 6. Se 10 10 10 10 10 10 10 10 10 10 10 10 10	7. Age (In y XI M 2□ F 74	rs. last birthday) Yrs.	If Under 1 Ye Months Da		Min.	8. Date of Bin (Month, Da 6/27/1	th ly, Yea 932	r) 9. Wa	Birthpla Countr ashi	ce (State or Foreign y) .ngton, DC
	yland how		10a. State 10b. County	10c.	City, Town or Lo	ocation				-		10	d. Inside City Limits
	Ba-fe	Director	Maryland Wicomi	co	Salisbu								1 ☐ Yes 2 ☐ No
	with ti		10e. Street and Number			10f. Zip Cod				10g. C	Citizen of What	Countr	y?
36	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked other then "naturel", or items 23a or 28s-f show unastic event, if a Madical Examinar must be notified at	y Funeral	414 Pine Bluff 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Was Decedent of Yes, specify C	of Hispanic O Cuban, Mexica		ocify Yes or No Rican, etc.))-	USA 14. Race - A Black, W Specify:	/hite, et	c.
Ö	hours ture!	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed.	Year or Dates:		dent's Usual Oc				16h	Kind of Busine		ite
Maryland 21215-0036	hin 72 a. "na Medic	Completed	(Specify only highest grad	de completed) College (1-4or 5+)	(Give	kind of work do DO NOT use re	ne during mo tired)	st of worki	ng	160.	Kind or ousine	ss/indu	istry
21	ygiene ygiene ner the	Corr	12	_	Par	calegal					ttorney	?	
and	d be fill antal H	Be	17. Father's Name (First, Middle, Last)						(First, Middle, arland	Maide	en Sumame)		
ary Z	is 1 and 2 should of Health and Men tiem 27 te marke other traumatic	J.	Quincy Shrier 19a. Informant's Name/Relationship (T)	ype, Print)	19b. Maili	ng Address (Str				er, City	or Town, Stat	ө, <i>Zip С</i>	Code)
Σ	1 and 2 Health a tem 27 to		Ashley Shrier/dau			20 Rugby		Pasad	dena, M	D 2	1122		
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ I	Removal from State	o. Place of Dispo cemetery, crei	osition (Name of matory or other	place)	D	ate	20c.	Location - City	or Tow	n, State
			4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Vicena	S	alisbury	Cremat Name and Ad		4/13/	/07	Sa	lisbury	7, M	ID .
Ra	permit. Departr Importa eny Inju		VUP Hal	Lina CE	- 0	Hollowa 501 Sno	y Fune	ral H	lome Pro	ofes	ssional	As	sociation
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dine cause on each line.							7 130 2	1	Approximate nterval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aLung_Can	cer								onset and Death months
	Examiner			Due to (of as a cons	sequence of):							_	· · · · · · · · · · · · · · · · · · ·
#	₽ #	ner	Sequentially list conditions, I amy leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Smoking Due to (or as a nors	requence of):								0 years
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	coguence of							4	
8760,	certificate be executed nding physician and use as the burial-transit	dical E		Due to (or as a cons	saquanca or).								
٥	tificate ng phy as the	fedic		d.							_		-
O. Box	atter for u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etel death 3	Ectopic pregna Other (specify)					23d. Date of Month		/ Pay Year
ت. ت	w requires that the di been signed by the should be detached	by Ph	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause	given in Part	l.	23e. Did to	obacco	use contribute	to the	cause of death?
Space	law requires as been sign 2 should be								1 😾 🗎	res :	2 □ No 3 □	Probal	oly 4 Unknown
VItal Records,	alawr hasbe e 2sh	Completed							24a. Was autop	sy	prior	to com	sy findings available pletion of cause of
E E	icien: The law certilicate has rector, page 2 :		05 W						1 ☐ Yes	- 3350	death		□ No
	ysicien: is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 20 No	Hospital: 1 ☐ Inpatient 2	: ER/Outpatier	nt 3 DOA	O#		<i>Check only o</i> ne 5 ∑ Resid		6 DOther (6	anaifu)	-
וס ר	두 두 절		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year			njury at Work?		28d. Describe h			p o city)	
S S	ttending death. ctor: After y the funer	catle	2 Accident investigation 3 Suicide 6 Could not be			M 1	Yes 2						
DIVISION	s after o	Certification:	4 Homicide determined	28e. Place of Injury · A building, etc. (Spe	t home, farm, str ecify)	eet, factory, office	се	2	28f. Location (S City or Tox	Street a vn, Sta	and Number or te)	Rural I	Route Number,
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edicai	29a. Certifier (Check only one) 1 ☑ Certifying Phy 2 ☐ Medical Exami	rsician: To the best of my liner: On the basis of exam and manner stated.	knowledge, deatl ination and/or in	n occurred at the vestigation, in m	e time, date a ny opinion, de	nd place, a ath occurre	and due to the o	cause(date a	s) and manner nd place, and o	as stat	ned. he cause(s)
	To To t	Σ	29b. Signature and title of certifier				ense number	720	1		ate signed (Mo		ay, Year)
	103					\mathcal{D}	0039 nnett	-		9	1-18-0	/_	
	Va		30. Name and address of person who co	ompleted cause of death (I	tem 23a) (Type, Shury MI	print) Be	nnett	- Yu	MI	0			
ŧ	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig				10.	7				
	Registr	ar	ADD 1 0 2	לחח 🐔	4	- 4 -							

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar 29b. Signature

31. Date filed (Month, Day, Year) 1 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DR. MICHAEL M. PHILLIPS, MD, FACP, PC, 2021 K STREET, NW, WASHINGTON, DC

29d. Date signed (Month, Day, Year) APRIL 17, 2007

20006

			1- For State of Maryland / De C	pariment of Health an <i>ertificate of Death</i>		iene eg. No. 2 A A 7 - 1-1, 1, A 1
	Physicia	an	Decedent's Name (First, Middle, Last) ANN ELIZABETH BROOKS THOMPSON		2. Date of Dear Month APRIL	16, 2007 1:38 A M
America	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of D		4c. County of Death
	Funeral		CIVISTA MEDICAL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	LA PLATA ay) If Under 1 Year If Under 24	Hrs. 8. Date of Birth	CHARLES 9. Birthplace (State or Foreign
	Director		220-28-6544	Months Days Hours	JUNE 4,	Year) Country)
	ryland how Lat	L	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits
	with the Marylan a or 28a-f show be notified at	Director	MARYLAND CHARLES INDIAN H	IEAD 10f. Zip Code	1	1
	ath with 23a or ust be	ral Di	105 ELLERBE DRIVE	20640		UNITED STATES
980	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces 1 □ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, P □ Yes 2 Ano Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
15-0	in 72 ho n "natu Aedical	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of e. DO NOT use retired)	working	16b. Kind of Business/Industry
212	filed with Hygiene. other thai		3.5 YEARS	SECRETARY	Name (First, Middle, I	EDUCATION
land	should be find Mental Humarked otlumatic ever	To Be	17. Father's Name (First, Middle, Last) BROOKS			OWN ELLERBE
Maryland 21215-0036	12 s har 7 is trau			ailing Address (Street and Number o		r, City or Town, State, Zip Code) TLANTA, GEORGIA 30314
	Heg the		•	sposition (Name of crematory or other place)		20c. Location - City or Town, State
Baltimore,	permit. Pages Department of Important: If it any injury or o		4 □ Donation 5 □ Other (Specify) ST. CHA			GLYMONT, MARYLAND
e Ba	Depart any any once	1	LEADTH C. TURKINION POLITICAL MODES		KUAD, INDI	AN HEAD, MAKILAND 20040
The Paris	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MYOCARDIAL INFAR Due to (or as a consequence of): C	ACTION OPEN	diac or respiratory arri	est, Approximate Interval Between Onset and Death
.O. Box 68760	The law requires that the death certificate be executed the has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	Physician/Medical E		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		pacco use contribute to the cause of death? es 2 □ No 3 □ Probably 4√□Unknown
Vital Records,	: The law requ cate has been , page 2 should	Completed	Rendersuffry		24a. Was a autops perfort	n 24b. Were autopsy findings available prior to completion of cause of
. VIta	/sician: Th s certificate director, pag	To Be	25. Was case referred to medical examiner? 1	Othor	Death (Check only on	e) ence 6 □Other (Specify)
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification: T	27. Manner of Death 14 Natural 5 Pending investigation 3 Suicide 4 Homicide 5 Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	e of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe ho	ow injury occurred reet and Number or Rural Route Number,
	he Hospital n 24 hours he Funeral bletely filled	edical Ce	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, do 2 ★ Medical Examiner: On the basis of examination and/o and manner stated.			
)	To t withi To tl	Me	29b. Signature and title of cartifier MA Jeutha My	29c. License number 2103	Ì	9d. Date signed (Month, Day, Year)
9	1810		30. Name and address of person who completed cause of death (Item 23a) (Type 131. Date filed (Month, Day, Year) APR 1 9 2007 32. fegistrar's Signature	Pe, Priot) 2070 OLD LIN	E CENTER,	STE.302 WALDORF,MD 2060
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 9 2007 32. Fegistrar's Signature	Anack .		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physici<u>an</u> Thomas April 17, 2007 Richard Trader, Sr. 0830 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. **X**□M 2□F Yrs. Director 218-56-3520 55 October 6,1951 Washington DC Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show VA West Moreland permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified. 1 ☐ Yes 2√ No Montross Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 374 Beacon Court 22520 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 If Yes, Give 2 □ No 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify <u>ک</u> White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Firefighter County Fireman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Thomas Trader, III Della Mae Williams ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ann Trader/Wife 374 Beacon Ct. Montross, VA 22520 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Brinsfield-Echols Crem. 4/21/07 4 ☐ Donation 5 ☐ Other (Specify) Charlotte Hall,MD 21. Signatura of Funeral Service Ligensee 22. Name and Address of Facility
AREHART-ECHOLS FUNERAL HOME, P.A. M01458 Viel T. Edward 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20646 Approximate Interval Between Onset and Death Immediate Cause (Final CANCER **Physician** ESOPHAGEAL disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** DIABETES MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy signed by the atter Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 21 No 1□ Yes Hospital or Attending PhysIclan: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 □ Yes 2 □ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D48158 APRIL 17, 2007 andrewsour

State Registrar

DHMH 17 Rev 1/2001

ROAD

500

OXON HILL MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

OXON HILL

32. gistrar's Signature

OSIA, 6192

31. Date filed (Month, Day, Year)

		1	For State Registrar		State of	Marylan		artmen r <i>tificat</i>			and M		giene Reg. No.		11.1.03
1	Physicia		Decedent's Name	_								2. Date of De Month	Day	y Year 2007	3. Time of Death 9:55 aM
Ŀ	/Medic		4a. Facility Name (If	not institution, give		per)		4b. City,	Town, or	Location of	of Death	Apri1		County of Death	1
	Examin	er .		6 Hottinger		,			Germa	ntown				Montgom	ery
	Funeral		5. Social Security Nu	umber 6. Se	ex 7	. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th av. Year)	9. Birth	nplace (State or Foreign untry)
ю	Director		218-75-61		□M 2 X F		Yrs.	9	22	Tiodis		June 24,			yland
	P .		Usual Residence of	Decedent 10b. County		10c Cib	y, Town or Lo	ocation							10d. Inside City Limits
	arylar show d at	ž	10a. State			700. 011	y, 101111 01 E								1 XYes 2 No
	he M 28a-f otifie	Director	Maryland 10e. Street and Nun	Montgo	nery			10f. Zip	antow Code	n			10g. Cit	izen of What Co	untry?
	a or			6 Hottinger	r Circle			7 3 11 2 1	2087	4				U.S.A.	
	ns 23	Funeral	11. Marital Status	0 Hotelinge	12. Was Deced	lent Ever in U.	S. 13.	Was Dece			igin? (Spe	ecify Yes or No Rican, etc.)	0-	14. Race - Amer	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur		ed 2 Married	Armed Ford 1 ☐ Yes 2 If Yes, Give Year or Date	2 🔀 No		1 ☐ Yes		Specify:		nican, etc.)		Specify: Car	ucasian
21215-0036	hour tural	90		15. Decedent's Ed	lucation		16a. Dece	dent's Usu	al Occupa	ation			16b. K	ind of Business/l	
5	in 72 n "na Medic	Completed	(Spec	ify only highest gra	de completed) College (1-	4or 5+)	(Give	kind of wo DO NOT u	rk done d se retired	during mos l)	st of work	ing			
212	i with	E	O	ilidally (0-12)	College (1			No	ne				l	None	
פַ	e filed al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last))					18. Moth	er's Name	(First, Middle	e, Maider	Surname)	
<u>la</u>	should be and Mental s marked or umatic eve	2	Mike	Raymond Va	ren						3	Michele	_		
	2 sho and l is ma	1 69	19a. Informant's Na	ame/Relationship (Type. Print)									or Town, State, Z	
	1 and 2 Health em 27 i			laren - Fat	her	20h F	19376 Place of Disp			ircle		nantown, Date		cation - City or	
ore	ges 1 t of H if iter		20a. Method of Disp 1 ☐ Burial 2	osition ⊠Cremation 3 □	Removal from S		cemetery, cre	matory or	other plac	e)			200. L	ocation - only of	Town, State
Ħ,	tmen tant:			5 ☐ Other (Specif		For	t Linco	1n Cre			4/23	2007	Bre	ntwood, Ma	aryland
Baltimore,	permit Depar Impor any in		21. Signature of Fu	The control of the co	1see		1	lines-l	Rinald	i Fune	eral I	lome, Inc	lver S	Spring, Ma	ryland 20904
	12 -		23a. Part1 Finer t	he disease, or com	plications that ca	used the deat ach line.	th. Do not er	ter the mo	de of dyin	ig, such as	s cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician	1	Immediate Cause (disease or conditio	(Final		monia									Oliset and Death
	/Medical		resulting in death)		Due to (or as a conseq	uence of):								
	Examiner	l.	Sequentially list co if any, leading to in	nditions,		hragiat		ia							
	pe țis	ine	if any, leading to in Cause (Disease or that initiated events	nmediate chyling injury	Due to (or as a consec	quence oi).								
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death)	Last	cDue to (or as a consec	quence of):								
68760,	be e sician buris			- L	d										
687		edical													
Вох	death certiff e attending d for use as	M	IF FEMALE: 23b. Was deceden	it pregnant	23c. If yes, out	come pf pregn		□Ectopic i	regnancy	u.				23d. Date of de	
	that the death certified by the attending detached for use at	Physician/Me	in the past 12 1 ☐ Yes 2	x No		ant et time of		Other (s						Month	Day Year
P.0	at the by th	ار چ	9 □ Unknowr				tai in als -		anua a air	en in Dort		230 Did	tobacco	use contribute to	the cause of death?
	es gn	by	Part II. Other signi	ficant conditions	continbuting to de	ath but not res	sulting in the	undenying	cause giv	en in Fait	1.				robably 4 Unknown
Records,	w requir been si should	Completed												111	
Sec.	2 % B	nple										24a. Wa aut	opsy formed?	prior to death?	utopsy findings available completion of cause of
필		ပ်							_			1 Yes	2 x N		2 □ No
Vit.	Physician: this certific ral director,	Be	25. Was case refe examiner?		Hospital:		TER/Outrati	ent 3□□	Oth	or:		th Check onl		6 □Other (Spe	noise!
or Vital		2	1 ☐ Yes 2 🕱		28a. Date	of Injury	ER/Outpation 28b. Time	of	28c. Inju		ursing n	28d. Describe			city)
	ding I h. After funer	ţi	1 🕱 Natural 2 ☐ Accident	5 ☐ Pending investigation		h, Day Year)	Injury	М		rk? Yes 2.[□No				
Division	spital or Attending tours after death. neral Director: After filled in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	20e, Flace	of injury - At h	nome, farm, s	treet, facto	ry, office			28f. Location City or T	(Street a	and Number or R	ural Route Number,
ō	in Diffe	Seri	1 4 Littomicide								- J				
	공부 교 (e)	edical (29a. Certifier (Check only one)	1 ☑ Certifying P 2 ☐ Medical Exa	miner: On the b	best of my kn asis of examin ner stated.	owledge, dea nation and/or	ath occurre investigation	d at the ti on, in my	ime, date a opinion, de	and place eath occu	, and due to the rred at the time	ne cause(e, date a	(s) and manner a nd place, and du	s stated. e to the cause(s)
	To the Hos within 24 ho To the Fun completely	Med	29b. Signature and	d title of certifier					9c. Licens	se number	r		-	ate signed (Mon	
	7		1 Cim	thea m	n Mil	lean	m D	00	400	2580	032		a	pril 17,	2007
	ے			dress of person who											
				a M. Willia	ms. D.O	6001 Mu	ncaster	Mill	Road,	Rockv	ille,	Marylan	d 208	55	
	St	ate	31. Date filed (Mo.	nth, Day, Year)	007	tegistrar's Sigr	nature	mark	,						
	Regis	trar	A	PR 19 21	OO!	MARI J		-							

DHMH 17 Rev 1/2001

07-03233 Howard Lewis Wood Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 14404

	1- For State Registrar		Certifica	ate of i	Death					Reg. No.		2. Time of Dooth
Physician/ Examiner	Decedent's Name (First, Midd	HOWARD	LEWIS	WOOD					Date of De Month April 28,	Day 2007	Year	3. Time of Death 0646 hrs
	4a. Facility Name (if not instituti 4 O'Brien Avenue	on, give street and number)		41	b. City, Tow Taneyto		cation of			Ca	rrDII	
Funeral Director	5. Social Security Number 120–60–7726	6. Sex 7. Age	e (In yrs. last birt 29	hday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24Hrs. Min.		3irth(MM/DE 16/197	I C	Birthplace (State or Dreign New York Country)
	Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town									10d. Inside City Limits 1 X Yes 2 No
he Maryland tor 28a-f show any diffed at once. Director		rroll	1ale)	y cown	10f. Zip Co		_		41 =1	10g. Citize		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland had Mental Hygiene. had Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once. To Be Commileted by Funeral Director		12. Was Decedent Armed Forces?		lf Y∈	s Decedent es, specify (of Hispa Cuban, I	Mexican, I	n? (Spe Puerto R	cify Yes or lican, etc.)	s or No- tc.) 14. Race - American Indian, Bla White, etc. Specify: White		
hours after d	3 Widowed 4 D	ivorced If Yes, Give Year or Dates: pecify only highest grade con	npleted) 16a.	Decedent during mo	Yes 2 X	ccunatio	n (Give ki	nd of wo	ork done	16b. Kir	nd of Busin	ness/Industry
snd 2 should be filed within 72 hours after the alth and Mental Hygier than "natural", traumatic event, the Medical Examiner To Be Completed by 1	Elementary/Secondary (0-12 12 17. Father's Name (First, Middl			handy	man	18				e, Maiden S		rovement
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MD 2121 d 2 should be fi lith and Mental n 27 is marked aumatic event,				4 0'	Brier	n Av	enue	per or Ri	aneyt	own, N	Maryl	State, Zip Code) and 21787 city or Town, State
of H	20a. Method of Disposition 1 Burial 2 X Cremati 4 Donation 5 Other		20b. Place crema Smith	sburg	ner place) g Crer	nato	rium		Date il 30 2007	' Sm:	ithsb	urg, Maryland
Baltimo permit. Pag Department Important: injury or o	21. Signature of Funeral Servi	ge License		1136	5 East	t Ba	ltim	ore	Stree		neyto	wn, Md. 21787
ysician ledical Examiner	23a. Part I Enter the disease, failure. List only one cau Immediate Cause (Final disea or condition resulting in death	se on each line. se aNarcotic_(heroin) i			dying, s	such as ca	ardiac or	respiratory	arrest, snot	or, or ricar	Between Onset and Death
No. E. Col.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cau (Disease or injury that initiate events resulting in death) La:	Due to (or as a cons	sequence of):								_	
	XUNPENDED	a. AMENBED PII			Æ, g86	8, 6,	/7/07	TT		230	I. Date of d	delivery
Box 6876 cath certificate the attending phy		4 Pregnant a		2 F	etal death other (Spec	3 [:ify) _	Ectopie	c pregna	ncy		Month	Day Year
ires that the death certific signed by the attending for the detached for use as if the detached for u	Part II. Other significant cor		ath but not result	ting in the	underlying	cause g	iven in Pa	art I.				oute to the cause of death? Probably 4 Unknown
cords aw requestable to the seconds and a seconds	Cocaine us	2							a	Vas an autopsy performed?	pr de	Vere autopsy findings available rior to completion of cause of eath? Yes 2 No
tal Recchan: The lacentificate lacetor, page		tical					of Death	(Check				
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on of \\ nding Phy ath. r: After the funeral	27 Manner of Death	28a. Date of Ir (Month, Da) Fnd 4/28		b. Time of	,	-	ry at Worl		unk	ribe how inj		
Divisior pital or Attend ours after death teral Director: filled in by the	3 Suicide 6 X	determined (Specify)	Injury - At home NOUSE						4 0 B	rien Av	ve. Tar	er or Rural Route Number, City neytown, MD
To the Hosp within 24 hos To the Fune completely fi		g Physician: To the best of Examiner:On the basis of each manner state	xamination and/	death occ	ation, in my	opinior	n, death o	ccurrea	d due to the at the time,	date and pi	ace, and di	de to the cause(s)
1	29b. Signature and title of ce				290		M.E.				Date signe ril 29, 20	ed (Month, Day,Year)
Ø	30. Name and address of pe Margarita Korell M		of death (Item 23 al Examiner	111	Penn Str	reet, B	Baltimor	e, MD	21201			
Sta Regist	ate 31. Date filed (Month, Day, Y	gar) 2007 32. Regis	trar's Signature	Loan	E)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 10:27 PM mma 2007 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center nce beorges If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State of Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 200 F 510184064 Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show item 27 is marked other than "natural", or items 23a or 28a-1 shov other traumatic event, it a Madical Examinar must be notified at 1 Yes 2 □ No Funeral Director Georges 10g. Citizen of What Country? 10e. Street and Number 908 1514 41115 20785 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Be Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OUDLIDI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be item 27 is marked o 2 Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 908 Central Hills Lane Hyallsville MDZ0785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of the importent: if ite any injury or ol once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Crember 4-24-2007 Kanas City 22. Name and Address of P cility Greene Funder H 21. Signature of Funeral Service Licensee

Nels E Shus 814 Franklin Street Alexandria via 22314 23a. Part 1. Enter the disease, or complication. That caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALZHEIMER'S DISEASE **Physician** /Medical Due to (or as a consequence of): Examiner SEIZURE DISORDER Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed SICK SINUS SYNDROME use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. attending physicien HYPERTENSION Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ŽUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy 1 ☐ Yes 2 ☐ No or Attending Physicien: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 🗶 No 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred s after death. si Director: After t 28c. Injury at Work? 5 Pending 1 XNatural investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

ENTRAL 31. Date filed (Month, Day APR 1 9 2

and address of person who completed cause

30.

8 CHELLVIL 32. Registrar's Signa

V

of death (Item 23a) (Type, Print)

State Registrar D0034

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			State of Marylai		artment of He rtificate of D		entai Hygiei Reg.	275 275 E 1871	11.1.05
F	EE		Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		PAUL WALTZ	ER			04/18/20	07	8:00 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Death ER SPRIN	C	4c. Counfy of Death	GOMERY
	Funeral	-		. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye		place (State or Foreign intry)
	Director		119-20-4295 1xx 2□F 77	Yrs.	Months Days	Tiours Iviiri.	06/03/192	9 NEW	
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. County	ity, Town or Lo	ocation				10d. Inside City Limits
:	Maryl -f sho fied a	ţo	MARYLAND MONTGOMERY SI	LVER S	PRING				1 X Yes 2 No
	th the or 28¢ e noti	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	
	s 23a	srall	15101 INTERLACHEN DRIVE #903	118 113		0906	ecify Yes or No-	U.S.	
9	s 1 and 2 should be filed within 72 hours after death with free Maryland. Health and Mental Hygiene. It Health and Mental Hygiene. It flee the 71 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: KORE		Was Decedent of Hisp If Yes, specify Cuban 1 ☐ Yes 2 ※ No	, Mexican, Puèrto Specity:	Rican, etc.)	Black, White	, etc. HITE
5	72 hou natura lical E		15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupat to kind of work done du DO NOT use retired)	ion Iring most of work	ing 16i	b. Kind of Business/li	ndustry
7	ithin /	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	`life.	DO NOT use retired) SALES PE			INSURA	NCE
7	filed w Hygie ther t	S	17. Father's Name (<i>First, Middle, Last</i>)				e (First, Middle, Mai		
	uld be rked o ric eve	To Be	LOUIS WALTZER			NETTIE G	OTTFRIED		
Ĕ	nd 2 should alth and Men 27 is marke r traumatic	1100	19a. Informant's Name/Relationship (Type. Print) ETHEL WALTZER/WIFE		ing Address (Street ar 1 INTERLAC				ip Code) G,MD 20906
e,	es 1 a of Hez		ASSESSMENT OF THE ASSESSMENT O	cemetery, cre	osition (Name of ematory or other place) :	1	c. Location - City or	
Baitimo	t. Pag rtment rtant: I rjury c	Н	4 □ Donation 5 □ Other (Specify)		ID MEML GD				H, VIRGINIA
ם ב	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Sign it, p of run Service Licensee	1_	2. Name and Address DWARD SAGE 1091 ROCKV	ILLE PIK	E, ROCKVI	LLE, MARY	
		01 17	23a. Part1 Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	ath. Do not er	nter the mode of dying	, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
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8/60	icate be executed physician and s the burial-transit	edical E	d				·		
9			IF FEMALE:	-				1	1
.O. Box	The law requires that the death certific that has been signed by the attending page 2 should be detached for use as:	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	etal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of del	ivery Day Year
7	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not re	esulting in the	underlying cause give	n in Part I.		cco use contribute to	
rds	equires en sign	ed by					1 ☐ Yes	2 No 3 Pr	obably 4 Unknown
Records,	law re las ber	Completed					24a. Was an autopsy	24b. Were au prior to death?	itopsy findings available completion of cause of
_	sician: The law s certificate has t irector, page 2 s						performs		2 No
Vital	ysiciar is certif directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	ent 3 DOA Othe		th <i>(Check only one)</i> ome 5 Residen	ce 6 □Other (Spe	cify)
פֿר	iding Phy h. After this funeral c	H-1	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year	28b. Time Injury	Work		28d. Describe how	injury occurred	
Sior	tendir eath. tor: Af the fur	catio	2 Accident investigation 3 Suicide 6 Could not be	home farm s		/es 2 □ No	28f Location (Stre	eet and Number or Ri	ural Route Number.
Division or	after death after death Director:	Certification:	4 Homicide determined building, etc. (Spe	ecify)	street, factory, office		City or Town,	State)	37317712319
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifics completely illied in by the funeral director,	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam and manner stated.	knowledge, dea ination and/or	ath occurred at the tim investigation, in my op	ne, date and place pinion, death occu	, and due to the cau irred at the time, dat	use(s) and manner as te and place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License			d. Date signed (Mont	th, Day, Year)
	1	8	Oynthia m Mille	eme		05803.	2 16	yrux 1	SI LUUT
	1		30. Name of address of person who completed cause of death (IDR. CYNTHIA M. WILLIAMS, MON'	tem 23a) (Type TGOMERY	e, Print) THOSPICE,	6001 MUI	NCASTER M	ILL RD, RO	20855 CKVILLE,MD
	CA.	ate	31. Date filed (Month, Day, Year) 32 Registrar's Si						

Registrar





			For State Registrar	State of Ma	arylan		artmen <i>rtificat</i>			and M		iene eg. No.	07	14407	1
	Dharisi		1. Decedent's Name (First, Middle, Last								2. Date of Deat Month	h Day_	Year	3. Time of Death	
	Physici /Medic		Juanita A	nnette	Wi	right					April	15,	2007	0420 M	
	Examin		4a. Facility Name (If not institution, give SALISBURY REHAB	street and number) & NURSIN	IG CE	NTER			Location of		21804		nty of Death	.co	
	Funeral Director		5. Social Security Number 6. Se 221–16–2019	M 2FF	e (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day)	Year)	Cou	olace (State or Foreign ntry) inia	,
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits	_
	Aaryk Pope	ō	Maryland Wicomic	-		Salisbu								1X Yes 2 □ No	
	the h	rect	10e. Street and Number		•	Darrosc	10f. Zip	Code			1	0a. Citizen	of What Cou	ntry?	_
	3a or	O	200 Civic Ave.					2180	04			US	SA		
3	death	Funeral Director	11. Marital Status	12. Was Decedent if Armed Forces?	Ever in U	.S. 13. \	Was Dece			gin? (Spe	ecify Yes or No- Rican, etc.)	14. F	Race - Ameri		_
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Ž	should be fand Mental I	2	19a. Informant's Name/Relationship (T)	(ne Print)		19b Mailin	a Address	(Street			I Route Number	City or Toy	un Stato 7i	2 Code)	
Ma	D = N =		Bruce A. Wright/so				-				Salisbu				i
a	Heal Heal tem 2		20a. Method of Disposition	JII	20b. F	lace of Dispo	sition (Nar	ne of	F				on - City or T		
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Baltimore,	permit. Pages 1 an Department of Heal Important: if Item 2 eny injury or other ance.	-	21. Signature of Epigera Cervice Licens		G	ardens ₂₂	Name ar	nd Addres							
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Вох	leath certific attending p	II/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pr	roonana.				23d.	Date of deliv	егу	
	ie deat the attr	Physician/Me	in the past 12 months?	4☐Pregnant at			Other (sp						Month	Day Year	
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of Vital Records,	The law requires that the death certificate be executed the hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions co	ntributing to death be	ut not res	ulting in the ur	nderlying o	ause give	en in Part I			oaccouse co os 2⊡no		he cause of death?	
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Ä		E C									perform	ned?	death?		
/ita	stcian: Th certificete rector, pag	Be (25. Was case referred to medical examiner?							of Death	(Check only on	e)			-
£	Physician: rthis certific ral director,	ဥ	1 ☐ Yes 2 ☐ No			ER/Outpatien			41 5040		me 5□ Reside			<i>(y)</i>	
	D 9 6	o E	27. Manner → Death 1 ➤ atural 5 □ Pending	28a. Date of Injur (Month, Da)	Year)	28b. Time of Injury		28c. Injury Work			28d. Describe ho	w injury occ	curred		
isic	r Attending er death, rector: After by the fune	Icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	iny - At h	ome farm etc	M oot factor		Yes 2□		28f Location (St	reet and Nu	mher or Rur	al Route Number.	_
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_	To the Hospital or within 24 hours afte To the Funeral Dirr completely filled in I	edical C	29a. Certifier 12-Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of nar: On the basis of and manner sta	examina	owledge, death	occurred vestigation	at the tim	ne, date an pinion, dea	d place, a	and due to the co	ause(s) and ate and plac	manner as s	stated. o the cause(s)	_
	o the o the o the	Me	29b. Signature and title of certifier	and marrier sta			290	c. License	number		2	9d. Date sig	ned (Month,	Dey, Year)	-
	⊢ 3 ⊢ 8		12/1/11	4			1	0-	> 9	70	9	4/	16/	~ ¬	
	1 mm		30. Name and address of person who co	ompleted cause of d	eath (Iten	n 23a) (Tvne	Print)		-/) >		1/1	4		
	Ul ""		WILLIAM ROBINS, M	•				SBUR	Y, MD	. 2	1804				
	Sta	te	31. Date filed (Month, Day, Year)	32. Pagistra		turo									
	Registr	ar	APR 182	UU/	w.	D. D	gardi	7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 14.43 PM Yaple Dorothy 04 2007 16 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** KENINSULA REGIONAL Nicomic 54/18**6UR**4 If Under 1 Year If Under 244 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ☐ M 2 😿 F 171-22-2535 80 Director Pennsylvania 12/5/1926 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maine Sagadahoc Topsham 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12 Curtis Lane 04086 Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Specify: 1 ☐ Yes 2 ☑ No Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene, Important: If item 27 is marked other than "in any Injury or other traumatin succession." Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wellington Yaple/husband 12 Curtis Lane, Topsham, ME 04086 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 4/17/07 Salisbury, MD 21. Signature of Funeral Servic (1) nsee Name and Address of Facility Holloway Funeral Home Professional Association 18 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASCUD Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jisasse or Lighry that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: esn. 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed I I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 → Ho 3 Probably 4 Unknown CAD page 2 should HTW 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No certificate has autopsy performed? Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐LER/Outpatient 3 ☐ DOA 1 Pres 2 No 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Medical Examiner:* On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and all the time, date and the time, 29a. Certifier Medical xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title

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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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hristopher Snyder

^{Year)} 1 8 2007

17/07

Carroll St. Salisbury MD 21801

	1 - For Stata Registrar		epartment of Health and N Certificate of Death	Mental Hygien Reg. No	CUUI ITTU.
Physician /Medical Examiner	Decedent's Name (First, Middle A Facility Name (If not institution,	rtes	4b. City, Town, or Location of Death	2. Date of Death Month Da	3. Time of Death
Funeral Director	4000 Cli	Ave 3. Sex 1 D/M 2 F 7. Age (In yrs. last birth 78 Yr	BALL Move	8. Date of Birth	
uth with the Maryland 23a or 28e-f show ust be notified at al Director	10a. State 10b. County	10c. City, Town of Balt	imore		10d. Inside City Limit:
be filed within 72 hours after death with the Maryland half Hygiene. Ital Hygiene. In other than "natural", or items 23a or 28e-f show event, the Medical Exeminer must be notified at Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in U.S. Armed Forces?	10f. Zip Code 2121 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerfo	(itizen of What Country? 14. Race - American Indian, Black, White, etc.
ed within 72 hours atl ygiene. Per than "natural", or it, the Medical Exemi Completed by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: Education grade completed) 16a. D	1 □ Yes 2 SNo Specify: ecedent's Usual Occupation Sive kind of work done during most of work fle, DO NOT use retired).	ang 16b. F	Specify: Black Kind of Business/Industry
d 2 should be filed with and Montal Hygiene. It is marked other then treumatic event, the Montal Hygiene. To Be Comp	17. Father's Name (First, Middle, L	College (1-4or 5+)	etal Mechanic	e (First, Middle, Maider	cial Security
	19a. Informant's Name/Relationsh Lelen Artes 20a. Method of Disposition	-Wite 400. Place of D	Mailing Address (Street and Number or Run Solution (Name of crematory or other place)	ve Balt	or Town, State, Zip Code) MOVE ND2(2) ocation - City r Town, State
permit. Pages 1 el Department of Hea importent: if item eny injury or other once.	1 Serial 2 Cremation 4 Donation 5 Other (Sp. 21. Signature of Funeral Service L	city)	22. Name and Address of Facility	3107 CO	wnsville, MD Baltimore, MD
Physician /Medical	23a. Part1. Enter the disease, or o shock, or hear failure. List o Immediate Cause (Final disease or condition resulting in death)	omplications that caused the death. Do not the death of t	enter the mode of dying, such as cardiac artic prostate can		Approximate Interval Between Onset and Death UNKNOWN
cate be executed by physicien and it the burial-transit and dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c. Due to (or as a consequence of):			
The law requires that the death certificate cate has been signed by the attending phys, page 2 should be detached for use as the Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
w requires that been signed b should be deta should by Pt	Part II. Other significant condition	s contributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ician: The law re certificate has be rector, page 2 sho Be Complet	25. Was case referred to medical			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
ding Phys	examiner? 1 Yes 2 No 27. Manner of Death 1 Xenatural 5 Pending 2 Accident investiga		tient 3 DOA Other: 4 Nursing Ho	me 5 A Residence 28d. Describe how injure	
itel or A its after rel Dire led in by	3 Suicide 6 Could no determin	building, etc. (Specify)		City or Town, State	
To the Hosp within 24 hou To the Fune completely fil	29a. Certifier (Check only one) 2 Medical Example 29b. Signature and title of certifier	Physician: To the best of my knowledge di aminer: On the basis of examination and/o and manner stated.	etti oncurred at the time, date and place, r r investigation, in my opinion, death occurr 29c. License number	ed at the time, date and	d place, and due to the cause(s) te signed (Month, Day, Year)
4	> Etson	o completed cause of death (Item 23a) (Ty	D24170		
State Registrar	ETSo MD Rich 31. Date filed (Month, Day, Year)	ey (tospice 838 N	Eutaw St Balti	more MD	21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month LUCY W. AGER APRIL 8:45P M 28, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 24411 MORGAN ROAD SAINT MARY'S HOLLYWOOD If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M **XX** F 78 VIRGINIA Director 430 52 1175 1928 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f si Examiner must be notified XXYes 2□No Directo DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 2918 P STREET, SOUTHEAST 20020 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes XNo
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXX No Specify þ If Yes, Give Year or Dates: Specify: BLACK XXWidowed 4 Divorced 'natural" Completed ed other than "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) DISTRICT OF COLUMBIA Elementary/Secondary (0-12) College (1-4or 5+) 12TH FOOD SERVICE WORKER PUBLIC SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked c JIM FOSTER ANNIE JACKSON 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i other tra PATRICIA CAPERS / DAUGHTER 24411 MORGAN RD. HOLLYWOOD, MD 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o once. XIX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CEMETERY 05/03/2007 BRENTWOOD, MD 21. Signature of Faneral Service License 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shockly, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2**XX**No Month Year 4□Pregnant at time of death 5 Other (specify) P.O. signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 x es 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No nas e 2 certificate ha performed?/ Yes 2022No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) DAUGHTER'S Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) RESIDENCE 1 ☐ Yes 🗶 🗓 No 2 ER/Outpatient 3 DOA မှ this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1XXNatural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: within 24 hours a

Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H005575 30. Name and address of p son who completed cause of death (Item 23a) (Type, Print) SCUMIDT, M.D. JENNIFER 40900 MERCHANTS LANE LEONARDTOWN, MD 20650 32. Registrar's Signature 31. Date filed (Month, Day, Ye. State

Charles and

Registrar

29a. Certifier

XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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760, ⁽¹⁾	te be executed	ysician and	e burial-transit

Division or Vital Records, P.O. Box 68

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Irene P. Bury May 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Nursing Home Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 200€ 95 Yrs. Director North Carolina 578-01-3474 2/14/1912 with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show notified at Baltimore 1 ☐ Yes 2 TX No Director Baltimore MD 10f. Zip Code 10e Street and Number 10a. Citizen of What Country? ō must be 21234 USA 2619 Moore Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. s 1 and 2 should be filed within 72 hours after if Health and Mental Hygiene. 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 Never Married 2 Married Po 1 ☐ Yes 2 ☑ No Specify white þ Specify: 3€Widowed 4 □ Divorced "natural", Completed er than "natur the Medical B 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) federal government secretary Ith and Mental Hygier

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traumatic event, the 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk. Ara P. Lyle ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a 2619 Moore Ave. Baltimore, MD 21234 Jean Edwards/ daughter 20b. Place of Disposition (Name of Evans Funeral Chapel – Bel Air 20a. Method of Disposition 20c. Location - City or Town, State May 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 5 ☐ Other (Specify) 2007 4 □ Donation Forest Hill, MD 22. Name and Address of Facility
Evans Funeral Chapel 21. Signature Vuneral Service Line 8800 Harford Parkville, MD Rd. 0 Cremation Services 21234 23a. Pal1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) C'ONGESTIVE HEART Due to (or as a consequence of): MYOCARDIAL INFIRCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical attending phy for use as the the Hospital or Attending Physician: The law requires that the death certifica IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 □ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D28987 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D Shoi LOCK BLUD BALTO SPERHNG 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Hospital or Attending hours after death .n 24 hou. Se Funeral P To the within

DHMH 17 Rev 1/2001 **OCME 2006**

29a. Certifier 1

31. Date filed (Month

29b. Signature, and title of certifier

Melissa Brassell, MD

Medical

State Registra

and manner stated

Assistant Medical Examiner

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

4 2007

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

May 1, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Item 20b per fh 9867 5-4-07 vt.
State of Maryland / Department of Health and Mental Hygiene amend item Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** LEROY BIAS 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALICE MANOR NURSING HOME BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1√2 M 2 🗆 F 220-24-8279 76 Director 11/07/1930 UNK Usual Besidence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Director N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2095 ROCKROSE Funeral AVENUE USA 21211 14. Race - American Indian. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2√2 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) LABORER LABORER 6ТН and Mental Hygid is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNK UNK 19a. Informant's Name/Relationship (Type. Print) LEGAL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is a
any injury or other trausonce. COMMISSION ON AGING & RETIREMENT ALICE BELLAMY ST. BALTIMORE MD

20c. Location - City or Town, State GUARDIAN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (*Specify*) 3 □Removal from State MT. CARMEL CEM. 5/3/07 BALTIMORE, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service Licensee 4600 LIBERTY HEIGHTS AVE, BALTIMORE, Approximate Interval Between Onset and Death Enter the disease, or complications that caused the doubt. Do not enter the mode of dying, such as cardiac or respiratory arrest, is, or heart feilure. List only one cause on each line. Immediate use (F disease condition resulting in death) Juse (Final **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to infinitionate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to for as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed res 20 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Mpnth, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

LIAQA

31. Date filed (Month, Day,

0346

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Year)

State

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

600. NONTH WOLFE STREET BACTIMONE MD 21287.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2<u>007</u> **Physician** P^{M} 29, April 5:40 Ernest William Barton, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Suburban Hospital Montgomery Bethesda | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year August 31, 1 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Birthplace Country)
Virginia **Funeral** 1 X M 2 □ F 79 Director 218-20-0553 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any lighry or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2K No Directo Damascus Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10724 Santa Anita Terrace 20872 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ⊠Yes 2 N9951-if Yes, Give 1956 Year or Dates: 1956 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing 1 1 2 1 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys Irene Hamman Charles William Barton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10724 Santa Anita Terrace, Damascus, Maryland 20872 Darlene M. Botsford / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Gaithersburg, Maryland
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc., 300 West Montgomery Avenue,
Rockville, Maryland 20850-2805 Forest Oak Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service M01473 23a. Partl. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death LUNG OWIGE Immediate Cause (Final YRS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) 68760 The law requires that the death certificate be by Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 Tyes 2 No signed by the 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed! Yes 2 No spiral or Attending Physician: The ours after death. leral Director: After this certificate I filled in by the funeral director, page Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3500 1 Yes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident 1niury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 023308 APRIL 30, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 6470 ROCKLEDGE DR. # 4100 BETTESDA, MO 308/7

State Registrar 31. Date filed (Month, Day, Year)

29 pry

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Squer 2:05 PM May 2007 Tain /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore show Hinking Bayeren Center are Date of Birth (Month, Day, Year, If Under 24 Hrs. If Under 1 Year Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 2□ F 219-12-7176 October 3,1923 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Seaford Delaware Sussex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19973 USA 26159 River Road Funeral 14 Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural". or item any injury or other transmits. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 💢 No Specify 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fabricator 12 years Designor years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theresa Short Christian Richard Bauer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11639 A Long Green Pike, Glen Arm, Maryland 21057 Daughter Paula Hill 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Medowridge Memorial May 5,2007 Halethorpe, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Fuperal Service Licensee. Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of): **Examiner** 4m Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, neral Director: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To after death. Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Day Month Year **Physician** John Milton Christenson 02, 2007 8:25 A. May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore County Heart Homes Assisted Living Lutherville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 🔀 M 2 🗆 F 85 119-03-8734 Nov.02,1921 Brooklyn, N.Y. Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10b. County 1 ☐ Yes 2X No Director Timonium Baltimore County Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a or 3 Examiner must be n United States 21093 2316 Eastridge Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 11. Marital Status Pages 1 and 2 should be filed within 72 hours after on the Health and Mental Hygiene.
nt: If Item 27 is marked other than "natural", or iten 1 □ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏃 No Specify: White þ Year or Dates: W.W.II 3 ☐ Widowed 4 ☐ Divorced the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Air Force Colonel 04 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Astrid Karolina Johansson Charles William Christenson ည permit. Pages and Department of Health and Inportant: If Item 27 is more injury or other traum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 324 Ringold Valley Circle Cockeysville, MD. 21030 Glenn S. Christenson (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition May 4, 2007 Forest Hill, Maryland Evans Funeral Chapel 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A. 21. Signature of Funeral Service License 21093 Timonium, Maryland 2325 York Road 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Weumentes Vecu N'ent **Physician** week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner month OLIAG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 24 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Aspled Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Wing FACLIA 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death After t (Month, Day Year) 1 Natural 5 Pending investigation 1 ∏Yes 2 ∏No M 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 ☐ Homicide within 24 hours a To the Funeral D hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MAy 2, 2001 address of person who completed cause of death (Item 23a) (Type, Print)

R. Ley, G. Benc 6701, N. Chan lo-N. Charles St. Balto. M.

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State

Registrar

31. Date filed (Month, Day, Year)

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32. Redistrar's Signature

Colors-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 11:42AM 02 narmes 05 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N Care Mt. Washington Baltimore 7. Age (In yrs last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 KF 077.20.8968 88 Yrs. MD Director Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "natural", or iteme 23a or 28a-f ebov treumatic event, the Medical Examinar must be notified at MD Battimore 1 XYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 21209 4669 Falls Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ient of Heelth and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 Yes Specify: Specify: Black þ lf Yes, Give **/** Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Privato Homemaker 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charmes Mae mna 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Heelth a. Important: If item 27 is eny injury or other treu once. Brenda Wright Road Randallstown Collier 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ■ Burial 2 Cremation 3 Removal from State Baltimore MD 05/08/07 Memorial 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Vally C. Greene Funeral Services 21. Signature of Funeral Service Licensee Road Bartimore MD 21212 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3mon this /Medical Due to (or as a consequent Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown 9 I Inknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 1 NO 3 ☐ Probably 4 ☐ Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No , page 2 s After this certificate has funeral director, page 2 2 1 Tes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 1 ☐ Yes 2 No Nursing Home 5 Residence 6 Other (Specify) ၉ 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. i Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours after To the Funeral Dire TO Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner/stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year, ause of death (Ite 67 010 31. Date filed (Month, Day, Year) 2. Registra 's Signature State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** W. Carnochan 8:00 9 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medicel Boltimore Hopkur Boyview Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1963 **Director** Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Xes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be I Savaa 91999 606 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ∐Yes 2 ∭ Mo If Yes, Give Year or Dates: Maryland 21215-0036 1 Yes 2 4No Specify Specify: ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be arnochan onna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mid haven Rd Dundal K, MD 20a. Method of Disposition

1 Burial 2 Cremation arnochan Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 Removal from State Metro Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) xemator -07 21. Signature Fin Al Service Licens 22. Name and Address of Facility pproximate nterval Between set and Death set and Death Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory/arrest, or heart failure. List only one cause on each line. 23a. Part1. shock, Immediate Cause (Final disease or condition resulting in death) Inhalotion **Physician** Smoke /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infiniteliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of): Examine and A burial-transit be executed Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? After this certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred spital or Attending Pinous after death.
Ineral Director: After till filled in by the funera 5 ☐ Pending investigation 1 Natural Injury House tire 11:52 PM April 18,2007 1 ☐ Yes 2 ☑ No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)
606 Saucze Boltomer Mi 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours at To the Funeral D House 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D Res-000 April 20 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 B-Itimore 4940 MO 21224 thoston Easlern Avenu 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #23a State of Maryland / Department of Health and Mental Hygiene Phy C867 5/04/07 JH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 10 CLARK ADELL 2007 /Medical An 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Walthw657 CENTER RANDALIS CONCE ATAL Baitrauna If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 3 Months 28-2760 1**X** M 2□ F ountry Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Baltimore 1 ☐ Yes 2 No Director handalistum -28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or Hanwell Thoad Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 XYes 2 ☐ No If Yes, Give 'natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📜 No Specify. Completed by 3 Widowed 4 Divorced Year or Dates: Blach 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ntary/Secondary (0-12) than College (1-4or 5+) icent Technology Machinist marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Anna immons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hanvell And Mandallstain mo 21133
ion (Name of Date 20c. Location - City or Town, State un permit. Pages 1 and 2 s
Department of Health ar
Important: if Item 27 Is
any Injury or other trau Mary E. Clark 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 05:09:2007 Owings mills, mi 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Voughin C. Greene funcial Service 21. Signature of Funeral Service Licensee 728Liberty 8,0 hoad Mandalistan mo Vaughna Freene 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pneumonia Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of): Examiner CARDIO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or). The law requires that the death certificate be executed physician and the burial-transi and A Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as e attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) by the a 9☐ Unknown 9 Unknown signed by it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RADIATION INDUCED PRECTITIE AND CONTES ' END STAGE 1 Yes 2 No 3 Probably 4 Unknown RENAL DISTASE. Cocowany Actiny District 24a. Was an 24b. Were autopsy findings available prior to completion of eause of death?
1 □ Yes 2 □ No has autopsy Mellites with Hypes years POLITY OF Place of Death (Check only this certificate 25. Was case referred to medical examiner? or Attending Physician: Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | 10 1 Depatient မ 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) funeral 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: completely filled in by the f 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 19502 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MURRICHT HESPITAL B CONANAN GREANDO (in) PANDMISTERN 2/133 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAY 0 3 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** a M mes /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and nur Examiner If Under 1 8. Date of Birth Month Pay, Birthplace (State or Foreign Country) **Funeral** Months Days Director 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatht and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director t more 10f. Zip Code 10e. Street and Number 21216 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle 18. Moth s Name (First, Middle Be Street and Number or Bural r, City or Town, State, Zip Code) Route Numb 20h Place of Disposition 20c Location 20a. Method of Disposition 2 Cremation 3 ☐Removal from State timore 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Weeks /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the is completely filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tyes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 22 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital or A 24 hours after 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 30. Name and address of person who co 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 0 4 Registrar

within 2 D

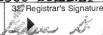
FLORENCE COLOSINO

2007

State Registrar

TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) MAY 0 4 2007

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** COVEL ANNIE R. 04/ 2007 P 18/ 9:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1641 Chilton Street Baltimore 8. Date of Birth (Month, Day, Year) 11-20-1943 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
N • C • Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 □ M 2 XF 217-40-7651 63 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 De Yes 2 □ No BALTIMORE Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21218 1641 CHILTON STREET U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. within 72 hours after 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Completed by 3 ☐ Widowed 4 Divorced 27 Is marked other than "natural"; traumatic event, the Medical Exa 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE Elementary/Secondary (0-12) College (1-4or 5+) filed withii Hygiene. 10th BUS DRIVER SCHOOL SYSTEM 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be fi Mental H Is marked UNKNOWN MARY ANN GREEN t and 2 should by Health and Ment ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LOUISE GREEN - DAUGHTER 4800 STRATHDALE RD., BALTIMORE, MD 21206 item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of h permit. Pages
Department of
Important: If it
any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State MT. CARMEL CEM. 05-05-2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Addresonally TAYLOR, II FUNERAL HOME Konald 108 WEST NORTH AVENUE, BALTIMORE, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** HTHEROSCLEROTIC CARDIOVASCULAR disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner upertersion Sequentially list conditions, Due to (ur as a consequence of) it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant The law requires that the death 3 ☐ Ectopic pregnancy Day Por in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year signed by the at d be detached fo 5 ☐ Other (specify) O 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 21 No page 2 s certificate 1☐ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 5 Pending investigation nours after death.

neral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 295. Signature and title of certifier 020000 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21215 6821 Reistrotom OP 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 4 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 12:45 A May 2007 Ruth Catherine Cotton /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Harford Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Hours **Funeral** Days Months 1 □ M 2 □X 5, 1923 Maryland Director 83 216-16-9341 Usual Residence of Decedent 10d, Inside City Limits death with the Maryland 10c. City, Town or Location 10a State 10b. County 28a-f show 1 □ Yes 2 TNo notified Directo Maryland Forest Hill Harford 10g. Citizen of What Country? 10e. Street and Number must be n 21050 2430 Johnson Mill Road Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No 6 Specify: ģ 3 XWidowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Rehabilitation Center Receptionist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Katherine Margaret Jenkins Thomas (unk) Childs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2430 Johnson Mill Road, Forest Hill, MD 21050
Disposition (Name of Date 20c. Location - City or Town, State Richard Allen Cotton/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 70 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hillton Service Corp. 5-4-07 T 22. Name and Address of Facility McComas Funeral Home, P.A. Towson, Maryland 21. Signature of Funeral Service Licensee 50 W. Broadway, Bel Air, Maryland 21014 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Duy to (or as a consequence of): /Medical with Mehisteries Examiner sevite cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and use as the burial-tra Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown s been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page / perform 1□ Yes 2000 25. Was case referred to medical examiner? 26. Place of Death Check onl one Medical Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[] No 1- Impatient 2 ER/Outpatient 3 DOA 1 ☐ Yes funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0062765 m 500 Upper Chesapeake Dr. Bel Ar, mD 21014 address of rson who completed cause of death (Item 23a) (Type, Print) Year) 4 2007 31. Date filed (Month, Day, Yea State Registrar

			1- For State of Maryland / Departn Registrar Certific	ment of Health and Mercate of Death	ntal Hygie	6001 19460
	Physicia	20	1. Decedent's Name, (First, Middle, Last)	2.	Date of Death Month	Day Year 3. Time of Death
Н	/Medic	al	HICKA G. DITZ		May 1	, 2007 8:05 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. Franklin Woods Nursing Center	City, Town, or Location of Death Rosedale		4c. County of Death Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Under 1 Year If Under 24 Hrs. 8.	Date of Birth (Month, Day, Ye	9 Birthplace (State or Foreign
L	Director		215 22 3822 TOW 28 93 Yrs.	onths Days Hours Min.	an. 14, 19	Maryland
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locatio	on		10d. Inside City Limits
	Maryi -f sho	tor	Maryland Baltimore Essex	x		1 ☐ Yes 2X No
	h with the 23e or 28e	Funeral Director	10e. Street and Number 613 Weir Lane	of. Zip Code 21221	10g.	Citizen of What Country? USA
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked ther than "natural", or Items 23e or 28e-f show eumatic event, the Medical Exam act must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛱 No	Decedent of Hispanic Origin? (Specifs, specify Cuban, Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
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altimore,	permit. Pagas 1 and Department of Healt Importent: If Item 2 any injury or other once.		20a. Method of Disposition 1 Seurial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition cemetery, cremator 20c. Place of Disposition Cemetery, cremator 20c. Place o	ry`or other place)		c. Location - City or Town, State altimore, Maryland
Balti	permit. Departm Importe any inju		21. Sign ure of Funeral Service Ocensee 22. Na Bru:	me and Address of Facility Zdzinski Funeral 7 Old Eastern Ave	Home P.A	A. ex, Maryland 21221
			23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each fine.			Approximate Interval Between
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		Jer	Sequentially list conditions, if any, leading to arm additions cause. Enter Underlying Cause (Disease or injury)			
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<u>5</u>	shysic this ce	ျ	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3		5 Residence	e 6 Other (Specify)
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Division of Vital	Attendes iter des itector	Cer ification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office 28	f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)
Ω	To the Hospitel or Attending Physician: That within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	cal Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ (Check only 2 Medical Examiner: On the basis of examination and/or investi	curred at the time, date and place, and	d due to the caus	se(s) and manner as stated.
	thin 24 the Fi	Medical	one) and manner stated.	29c. License number		. Date signed (Month, Day, Year)
)	7 × 7 × 0		Dim Parshall M.A.	D4000 8		5/1/07
	۷		30. Name and address of person who completed cause of death (Item 23a) (Type Print	1)		
	5		JIM PARSHALL 9105 FRANK	LIN SQUARE	Dr. B	ALTIMORE, MD.
	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 4 2007 32. Registrar's Signature			
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	Physici /Medic		1. Decedent's Name (First, Middle, Last) MARY	DAY	2. Date of Death Month	Day	Yeer 2007	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County		
		n/	JOHNS HOPKINS BAYVIEW CARE	BALTIMORE		BALT	MOR	E CITY
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 1 M 2 🛣 84 Yrs.	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	May 5,	922 2007		ace (State or Foreign try) 1land
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation			10	Od, Inside City Limits
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	r 28e	Funeral Director	10e. Street and Number	10f. Zip Code	10	Og. Citizen of W	Vhat Count	try?
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	deat	ner		. Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race	e - America	
36	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Itams 23a or 28e-f show attic event, the Mindrell Examitter mast be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒No	1 ☐ Yes 2 X No Specify:	o nicari, etc.)	Specify	k, White, e Whi	
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L	Cxammer	_	Sequentially list conditions, b					
7	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its document of the conditions of the co					
/_	and al-trae	xan	that initiated events c. resulting in death) Last Due to (or as a consequence of):					
8760,	cate be executed physician and the burial-transit	dical	L d					
9	tificat ng phy as th	Aedi						
O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date Mon	e of deliver oth [y Day Year
م	res that the de signed by the a be detached t	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e. Did toba	acco use contri	ibute to the	cause of death?
Records,	uires l signe ld be	d by	HYPERTENSION, ATRIAL FIBE		1 □ Yes		3 ☐ Proba	/
S	w require s been si should b	Completed	CORONARY ARTERY DISIEASE)	24a. Was an	24b. W	Vere auton	sy findings available
	sician: The law certificate has b lirector, page 2 s	omp	THE THE PROPERTY OF THE PROPER		autopsy perform	ed? p	rior to com eath?	pletion of cause of
Vita		BeC	25. Was case referred to medical	26. Place of Dea	1 ☐ Yes 2 th (Check only one		☐ Yes 2	2 P NO
	Physici this cer al direc	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Other		nce 6 Othe	r (Specify)	
0	iding Phy Ih. After this funeral d		27. Mannay of Death 1 Natural 5 Pending (Month, Day Year) Injury 1 Natural 28b. Time (Month, Day Year)		28d. Describe hov	w injury occurre	ed	
<u>S</u>	Attendi death. ctor: A y the fu	cati	2 Accident investigation	M 1 ☐ Yes 2 ☐ No				
Division of	after d Diract Diract	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	eet and Numbe State)	er or Rural	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director,		29a. Certifier (Check only 2 Medical Exeminer: On the basis of examination and/or	th occurred at the time, date and place,	and due to the cau	use(s) and mar	nner as sta	ted,
	the H hin 24 the Fu	Medical	one) and manner stated.					
	To To cor	~	29b. Signature and title of certifier	29c. License number		d. Date signed		
	in		30. Name and address of person who completed cause of death (Item 23a) (Type	DOOG316L ASTERN AVE	7	- ر ۲۳۰	4,2	-00+
	10		ANIRUDH SZIDHAZAN 4940 E.	ASTERN AVE	BALTIA	10RE	MD	21224
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	ade				
	Registr	ar	MAY 0 4 2007 James St. Ag					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** May 3, 0:17 A Mary Virginia Dugan 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Greater Baltimore Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ м 2🗓 F 91 Baltimore, MD. 219-01-3739 Jan.19,1916 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any lipury or other traumatic event; the Medical Exminer must be notified at anones. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 200No Director Maryland Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1621 Jeffers Road 21204 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: Specify: White ģ 3 ☑ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12 n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest William Frey Mary Frey ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21152 Honorable Robert N. Dugan (Son) 6 Sparks Station Road Sparks, Maryland 20b. Place of Disposition (Name of cometery crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)
Dulaney Valley Mem. May 05, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 2007 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service License 2 23a. Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Quset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonitis Unknown **Physician** /Medical Due to (or as a consequence of): **Examiner** Unknown Cerebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner In necords, P.O. Box 68760, 4 physician and s the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death Dav 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Atrial Fibrillation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Coronary Artery Disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No perform 2 🗆 X lo To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death.

Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in 15 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05/03/2007 D0060248 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 North Charles St. Towson, MD 21204 C Greenawalt MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

07-03208 Debra Ellis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day April 27, 2007 Medical Examiner 0824 hrs Debra M. Ellis 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 4221 White Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** ForeignMaryland Months Davs Hours Director 213-68-0094 4/8/1956 51 Country) M 2 X F Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No 28a-f show MD Baltimore Baltimore the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number notified at 4221 White Ave. 21206 IISA 238 with 1 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status White, etc. white If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Yes If Yes. Give Year Widowed 4 Divorced Yes 2 X No specify: Specify: l other than "natural", the M. dical Examiner 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry uld be filed within 72 hours a Mental Hygiene. 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Assisted MD 21215-0036 12 house manager Living 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) marked Be Charles Thomas Ellis Frances Virginia Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Parkville Pages I and 2 should be ment of Health and Ment tant: If item 27 is mark or other traumatic even 19a. Informant's Name/Relationship (Type, Print) Stacey Ellis/ daughter 8424 Old Harford Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery May 3, 20c. Location - City or Town, State Baltimore, crematory or other place) ater Baptist Cemetery 1 X Burial 2 Cremation 3 Removal from State 2007 tant: or oth Baltimore, MD Donation 5/ Other Specify: ^{22. Name and Address of Facility}
Vans Funeral Chapel
Cremation Services 21. Signature of uneral Service Licenses 8800 Harford Rd. Parkville, MD MD 21234 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Hypertensive atherosclerotic cardiovascular discuss caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED sician burial 4 232,27, perME, G867, 5/16/07 TT requires that the death certificate be Box 68760. 23c. If yes, outcome of pregnancy 23d Date of delivery ending phy use as the b 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Dav Fetal death past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 🗸 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. O ģ Yes 2 ✓ No 3 Probably 4 Unknown Division of Vital Records, P. Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has performed? death? Yes 2 V No 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other, examiner? Hospital: Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 DOA this ۵ 1 V Yes Nο Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 X Natural Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. April 28, 2007 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Susan Hogan MD. Assistant Medical Examiner 32. Registrar's Signature Pay Year) 2007 State Registrar

0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401

ROTUKEN

Year

0 4 2007

OLD LOURT

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ELDERSBURG MO 21784 Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 4 Unknown 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Mo 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29c. License number 29d. Date signed (Month, Day, Year) 2007 RUMD RANDAUSTOWN MARY LANS 21133

3. Time of Death

11:05

Birthplace (State or Foreign Country)

MARYLAND

10d. Inside City Limits

1X Yes 2 □ No

Year

USA

14. Race - American Indian,

Black, White, etc

Specify:

BALTIMURE

2007

Registrar

State

MUNAEL

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTFW/17, perFH C867-5/24/07, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ") 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 2, 2007 **Physician** Ruth 12:20PM M Finch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 1 Month Day, 2 2 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1918 Months 1 □ M 2 🖵 F 88 Florida Director 218 82 7570 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐Yes 2√ No Director Maryland Prince George's Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e 14106 Brandywine Heights Road 20613 U.S.A. "natural", or Items 23a Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Iter Iry or other traumatic event, the Medical Examiner. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ₩idowed 4 Divorced ear or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than " Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Las 18. Mother's Name (First, Middle, Maiden Surname) Be 0wen Geneva Rosier ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9101 Robinson Street Brandywine, Maryland 20613 Julie Finch (Daughter-in-law) May Pate 2007 | 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Washington National Cem. Suitland, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lens 22. Name and Address of Facility Lee Funeral Home, Inc. 400153 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ARKRIO Scherotic Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the buria To Be Completed by Physician/Medical as attending properties as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day 5 ☐ Other (specify) by the a 1 □ Yes 2 ¶No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. -emu 1 ☐ Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 r this certificate has autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 2 Accident (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:,
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 735206

State

Registrar

DESCE!

11701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lliam

04

31. Date filed (Month, Day, Year)

TANNOWM

Registrar's Signature

Livingim Road, First WASHington,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 3. Time of Death **Physician** t Awcett JAMES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ma CATONSVIlle nen GARDIN Baltimore 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 15, 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months West Virginia Days Hours 1 M 2 □ F Yrs 83 236-24-8592 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ъ 21044 5225 Even Star Place USA "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any Injury or other trainment. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Mechanical Engineer Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanley B. Fawcett Evelyn M. Peters ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 5225 Even Star Place; Columbia, Maryland 21044 James Bruce Fawcett 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Crest Lawn Mem. Garden 5/8/2007 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licens Part I. Enter the disease, or cometications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal **Physician** disease or condition resulting in death) /Medical Due to (or as a cons quence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 24 To the I within 24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (9215 Maiden Choice Day, Year) 0 4 200 31. Date filed (Month,

32. Registrar's Signature

and manner stated.

NVD

(Check only

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1014

29c. License number

(atursville

29d. Date signed (Month, Day, Year)

2007

			State of Maryland / Dep 1- State Amend #30, perDVR, g807, 5/4/07 TI Ce	partment of Health and Mertificate of Death	lental Hygier	ne 007	14432
-	Physici /Medic		1. Decedent's Name (First, Middle, Last) ABNER WILLIAM (FOULDIN	2. Date of Death Month	Day 2 Year 2 2007	3. Time of Death HR
	Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number) 1751 Bloom Rd。 5. Social Security Number 217-26-4676 6. Sex 1 ☑ M 2 ☐ F 77 77	4b. City, Town, or Location of Death Westminster // If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 12–6–1929	4c. County of Death Carroll 9. Birthpi County Maryl	* -
Baltimore, Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "neturel", or Iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examiner is use be notified at once.	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I Maryland Carroll Westmins				od. Inside City Limits
		by Funeral Director	10e. Street and Number 1751 Bloom Rd. 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates:	10f. Zip Code 21157 Was Decedent of Hispanic Origin? (Spell Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2√√2 No Specify:	ecity Yes or No-	Citizen of What Coun USA 14. Race - America Black, White, e	an Indian, stc.
		To Be Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired) ations Manager 18. Mother's Name	ing	nchor Moto	•
			John Edward Gouldin Mary Elizabeth Neighoff 19a. Informant's Name/Relationship (Type, Print) Michael E. Gouldin— son Mary Elizabeth Neighoff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael E. Gouldin— son 1408 Valley Lane, Woodbine, MD 21797				
			20a. Method of Disposition 20b. Place of Dispos	position (Name of ematory or other place) pe Memorial Park 5/3/2	2007 E13	Location - City or Too kridge, MD	
				22. Name and Address of Facility ary L. Kaufman Fund 250 Washington Blv nter the mode of dying, such as cardiac o	d., Elkric	dge, MD 21	
of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien end imperior completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and in its page.	Certification: To Be Completed by Physician/Medical Examiner		MUNARY	FAILL		Onset and Death
				□Ectopic pregnancy □ Other (specify)		23d. Date of deliver	y Day Year
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Kinknown				
			HYPERTENSION DIABETES MELLITUS II 25. Was case referred to medical	24a. Was an autopsy performed? performed? 1 Yes 2 100 1 Yes 2 100 26. Place of Death (Check only one)			
			examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		Medical C	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)				
•	6+1		30. Name and address of person who completed cause of death (Item 23a) (Type	D 33599	. 0	4-30-	2007
	Philip John Ruzbarsky, MD Westminster, MD State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death s Name (First, Middle, Last) 2. Date of Death **Physician** sasque 8:00 PM mie 2007 /Medical Name (If not institution, give street and number) Town, or Location of Death Examiner atonsville saltimore If Under 1 Year If Under 24 Hrs. B. Date of Birth Months Days Hours Min. 07-08-6. Sex 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** -0896 1□M 2\ F Yrs. Director Usual Residence of Decedent 10b. Cqunty 10c. City, Town or Location 10a. State 10d. Inside City Limits A Shows and Montal Hygiene.
and Mental Hygiene.
le marked other then "netural", or iteme 23a or 28a-f ehow
raumetic event, it a Modical Examinar must be inclined at 1 ☐ Yes 2 No Director toward 10e. Street and Jumber 10f. Zip Code 10g. Citizen of What Country? Ambrosia 21 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17 Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle. Be 2 should be f and Mental I permit. Pages 1 and 2 should by Deportment of Health and Menta Important: If Item 27 is marked ery linjury or other traumetic space. 19a. Informant's Name/Ralationship (Ty 19b. Mailing A ress (Street and Number 20b. Place of Disposition (Name of cometery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State O 3 ☐ Removal from State 1 Burial 2 ☐ Cremation Baltimore 4 ☐ Donation 5 ☐ Other (Specify) Moria 21. Sig. at ve of Funeral Service Licensee er Pike, Batton 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metantes **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, havy, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dua to (or as a sonsequence of) signed by the attending physicien end be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 mopths? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ₹ 4 Donknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? this certificate 1 ☐ Yes 2 ☐ No of Vital 1 ☐ Yes 2 1 No Be 25. Was case referred to medical examiner? completely fitted in by the funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☐ No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After Certification: within 24 hours efter deeth. To the Funerel Director: A 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RB, catorpoille, MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 0 4 2007

32 Registrar's Signature

hristian J. Grab	F	State of Maryland / - For State Registrar		rtment of tificate of		and l	Mental	Hygiene	Reg. No	200	7 14431
Physicia ledical Examin		1. Decedent's Name (First, Middle,Last) Christian J. Grab						2. Date of D Month April 27	Day	Year	3. Time of Death 0650 hrs
		4a. Facility Name (if not institution, give street and number) St. Agnes		41	o. City, Tov Baltimo		cation of De			c. County of Death	
Funeral Director		213-11-4315 1XM 2DF	(In yrs. Ia	st birthday) Yrs.	If Under Months	1 Year Days	If Under 24I Hours M	din.	,	#DD/YYYY) 9. Bir Foreig	
v any	-	Usual Residence of Decedent 10a. State 10b. County 1	l0c. City,	Town or Location	n			.1			10d. Inside City Limits
Aaryland 28a-f show 1 at once.	to.	Maryland Baltimore 10e. Street and Number		Catonsv	ille	ode			10g. Ci	tizen of What Cou	1 Yes 2 X No
in the Maryland 23a or 28a-f sho	I Director	6507 Frederick Road			212	228			U	.S.A.	,
r death w or items must be	Fune	3 Widowed 4 Divorced If Yes, Give Year	X No	If Ye		Cuban, M	Mexican, Pue	Specify Yes or rto Rican, etc.)	No-	White, etc.	ican Indian, Black,
0036 within 72 hours after death with the Maryland jene. rer than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once.	Completed by	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5-		16a. Decedent during mo	s Usual Oo st of worki	cupation ng life. D	(Give kind O NOT use		work done 16b. Kind of Business/Indus		
215- be filed atal Hyg rked oth	Be Com	12 17. Father's Name (First, Middle, Last) James Robert Grab		Comput	er Te		.Mother's Na	me (First, Middl Elizabe	e, Maide	n Surname)	stem
MD 21 nd 2 should in the and Men m 27 is man aumatic ev		19a. Informant's Name/Relationship (Type, Print) Ann E. Grab (Mother)								City or Town, State	
lore, MD ggs 1 and 2 sk tt of Health an t: If item 27 i		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State	e c	Place of Disposit	er place)		•	Date -1-2007		Location - City or	
Baltimore, permit. Pages I at Department of Hee Important: If ite injury or other ir	t	4 Donation 5 Other Specify: Metro Crematory 5-21. Signature of Funeral Service Licensee 22. Name and Address of Facility Williams 15555 Twin KNolls							uner	atonsvili al Homes mbia, MD	. Tnc.
Physician /Medical :aminer	3	23a. Part I. Enter the disease, or complications that caused t failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	toxic	ation):	e mode of	dying, su	ich as cardia	c or respiratory	arrest, st	nock, or heart	Approximate Interval Between Onset and Death
uted d ansit	Exam	if any, leading to immediate CDisease or injury that initiated events resulting in death) Last Due to (or as a conservation of the conservation									
60, are be executed hysician and e burial - transit	Medical	X UNPENDED #231,27,28a	-f, p	erME, g86	8 , 6/1	1/07	TT				
687 certifica nding p		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcom 1 Live birth 4 Pregnant at t 9 Unknown	e of pregr	ancy 2 Fet	al death er (Specif	3	Ectopic pre	gnancy	2	3d. Date of deliver Month	y Day Year
P.O. es that the igned by t		Part II. Other significant conditions contributing to death	but not re	esulting in the u	nderlying c	ause give	en in Part I.				the cause of death? bably 4 Unknown
on of Vital Records, P.O. Box leading Physician: The law requires that the death anth. or: After this certificate has been signed by the atte the funeral director, page 2 should be detached for u	Completed by							pe	as an itopsy informed	prior to death?	utopsy findings available completion of cause of es 2 No
fital Residential Recipions of the string of	å	25. Was case referred to medical examiner? Hospital: 1 Inpatier	nt 2 🗸	ER/Outpatient	PT-	01	f Death (Che	ck only one)	Resid	dence 6 Othe	or·
Division of Vital Rec pital or Attending Physician: The ours after death. After this certificate filled in by the funeral director, page	ation: To	27. Manner of Death Natural 5 Pending 28a. Date of Injur (Month, Day, Ye	y ear)	28b. Time of Ir 6:05 pm	jury 28	c. Injury	at Work?			njury occurred	
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Certification:	3 Suicide 6 X Could not be determined (Specify) ho			t, factory, o	ffice buil	lding, etc.	28f. Locatio	n (Street a, State) ' rede 1	and Number or R	ural Route Number, City atonsville, MD
To the Hos within 24 h To the Fun completely	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my one) Wedical Examiner: On the basis of examone on the control of the basis of examone on the control of the cont	knowledg ination ar	ge, death occurr nd/or investigati	ed at the ti on, in my c	me, date pinion, d	and place, teath occurre	and due to the c ed at the time, d	ause(s) a ate and p	and manner as sta place, and due to t	ted. ne cause(s)
	Me	29b. Signature and title of certifier Lawrence The Yould				License r				Date signed (Mo	onth, Day, Year)
2 pro		30. Name and address of person who completed cause of de Margarita Korell MD. Assistant Medical I		er 111 Pe		et, Bal	timore, M	D 21201			
Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar		re d	ach						

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 2007 Year **Physician** May 2, 9:10 AM William Thomas Gisriel /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Blakehurst Health Center Towson Baltimore If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) 6. Sex 1 M 2 □ F If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Yrs. 219-18-0533 June 6, 1925 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Experience was to notified at 1 ☐ Yes 2 No Directo MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #453 21204 USA 1055 W. Joppa Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0020 white à 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Boylan Gisriel Anne Delores Lauttman 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Helen Gisriel / wife 1055 W. Joppa Road #453; Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/4/07 Hilltop Service Corp. Towson, MD 21. Signature of Fun ra Service Licensee 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical processestic cardiovascular disease **Examiner** Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this count. igned by the attending physician and be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Due to (or as a consequence of) 23b. Did tobecco use contribute to the ceuse of deeth? Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Wenssis 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 □Ynpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of iours after death.

neral Director: After the filled in by the funeral 5 Pending 1 ☐ Yes 2 🗆 No investigation 2 ☐ Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 11 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) BUTIMORE MO 6701 N CHARLES 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 4 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:25 JOHN L. GRAHAM 2007 O. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNION MEMORIAL HOSPITAL BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 214 20 7080 82 Director JAN.9,1925 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Yes 2□No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25TH STREET 401 E. APT.5F 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? N☐ Yes 2 ☐ N☐ 9 4 2 — 4 5 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify. δ Specify: BLACK 3√ Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9TH **HOUSEKEEPING** HOSPITAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FRED GRAHAM ANNIE MILBURN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ESTHER BROWN (sister) 6616 ELLSMERE PLACE BALTO, MD. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State GARRISON FOREST VET.CEM 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) OWINGS MILLS, MD. 22. Name and Address of Facility CRUGGS FUNERAL HOME ature of Funeral Service Licensee Ruradin PRESTON ST. BALTO, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hemorrhagic shock 24 hrs /Medical Due to (or as a consequence of) **Examiner** Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ician and burial-transit Division or Vital Records, P.O. Box 68760, E severe coronary artery disease Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No 1☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1X Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident (Month, Day Year) 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No Funeral Director: 6 ☐ Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital or / Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

State Registrar

29b. Signature and title of certified

31. Date filed (Month)

To the within 2

29c. License number

Union Memorial Hospital

AT 2438946

29d. Date signed (Month, Day, Year)

May 2nd

and manner stated.

gistrar's Signature.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>		nt of H		nd Me		ene	Parameter of the second		37
	417	À.	1. Decedent's Name (First, Middle, La	ist)					2	. Date of Death	n		3. Time of	Death
. "	Physici		Doris Ruth	Gigliott	i				1	Month	, Day 2007	ear	1:50	A M
	/Medic Examin		4a. Facility Name (If not institution, gi			4b. Cit	y, Town, or	Location of (4c. County of	Death	1.50	**
-	Examili	eı	Manor Care Rux				Ruxto				Balti		0	
	Funeral	-			(In yrs. last birthday)		ler 1 Year	If Under 24		. Date of Birth			lace (State o	or Foreign
Ţ	Director		217-07-2917	¹ □M ² [X]F 9	1 Yrs.	Month	s Days	Hours	Min.	(Month, Day, March 1	2.1916		vland	
	No.		Usual Residence of Decedent			1							<i></i>	
	ylan how		10a. State 10b. County		10c. City, Town or Lo	ocation						1	0d. Inside Ci	•
	Ma-1-s	i ci	Maryland Baltin	nore	Ruxt	on							1 🗆 Yes	2 XNo
	th the	Director	10e. Street and Number			10f. 2	Zip Code			10	og. Citizen of Wh	at Cour	try?	
	th wi		7001 N. Charles	Street			2120)4			U.S.A.			
	dea dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Dec	edent of Hi	spanic Origin	n? (Specif	fy Yes or No- can, etc.)	14. Race -	Americ White,		
9	or It	F	1 Never Married 2 Married	1 □Yes 2 ▼ N If Yes, Give	0		2 No	Specify:	40.10 11.	Jan, 5(5),				
ğ	ural',	d by	3 ₩ Widowed 4 Divorced	Year or Dates:			-X	Open,			Specify:	wnı	te ————	
2	natu	Completed	15. Decedent's E (Specify only highest gi		(Give	kind of	vork done d	luring most o	f working		16b. Kind of Busi	ness/In	dustry	
2	Mithin ne.	ш	Elementary/Secondary (0-12)	College (1-4or 5	+)		use retired,)			0 1			
'n	led v tygie her t		12th. Grade	*1	HC	omema	aker	10 Mathada	None (Circa Adiedello A	Own I			
Suc.	be fi	Be	17. Father's Name (First, Middle, Las							rirst, Middle, N	Maiden Sumame)			
$\frac{3}{5}$	nark	은	Samuel	Co1bo				Ma:					wes	
Maryland 21215-0036	12 sh h and 7 Is n traun	ı	19a. Informant's Name/Relationship			•	,				City or Town, St	. ,	,	
	deelt deelt m 2		Alfred Gagliot 20a. Method of Disposition	t1/Son	20b. Place of Dispo			CE.	Dat	keysvil	.le MD 20c. Location - Ci	210		
O	Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hyglene. Int: If item 27 is marked other than "netural", or iteme 23e or 28e-f show int: If item 27 is marked other than "netural", or iteme 25e or 28e-f show it y or other traumatic event, the Modical Examinar must be notified at		1XXXBurial 2 ☐ Cremation 3		cemetery, cre	matory o	r other place					•		
Ë	t. Pa tmer tant		4 □Donation 5 □Other (Spec	200	Most Holy						Baltin		MD	
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lice	nsee	2:	2. Name M	and Addres	Dippe	1 Fui	neral H	ome, Inc	2.		
	00500		Mm	17/						Balti) 2	1206 Approximat	
	Physician /Medical Examiner	Examiner	23a. Pari1. Enter the disease, or cof shock, or heart failure. List op Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a c.	Zheime a consequence of): a consequence of): a consequence of):	rs	de	ment	ria	Plation			Interval Bet Onset and	ween Death
.O. Box 68760,	The law requires thet the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 SNo 9 □ Unknown		B□Ectopic pregnancy □ Other (specify)					23d. Date of delivery Month Day Year		Year		
ds, P	uires the signed I Id be det	5	Part II. Other significant conditions	contributing to death bu	it not resulting in the u	ınderiyin	g cause give	en in Part I.			acco use contrib es 2 □ No 3	ute to tl □Prob		death? Unknown
CO	w require been si should b	lete							_	24a. Was ar	24h We	re auto	psy findings	available
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Vit.	Physician: The rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hannitali			1 4		f Death (Check only on	θ)		-	
5	hysithis caldir	ို	1 Yes 2 No	Hospital: 1 Inpatie				4 Murs			nce 6 Other		r)	
Ē	ing F After unera	on:	27. Manner of Death 1 St Natural 5 □ Pending	28a. Date of Injur (Month, Day	y 28b. Time of Injury		28c. Injury Work			d. Describe ho	w injury occurred	i		
Sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not			М	1 🗆 '	Yes 2□No)					
\leq	l or At after o Direct	Certification:	4 Homicide determine		iry · At home, farm, st :. <i>(Specify)</i>	reet, fact	ory, office		28	f. Location (Sti City or Town	reet and Number ı, State)	or Rura	l Route Num	nber,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.													
	To the Hospitel within 24 hours a To the Funeral completely filled	edicai	(Check only 2 Medical Exa	hysician: To the best of minar: On the basis of	examination and/or in	th occurrences	ed at the time on, in my op	ne, date and pinion, death	place, an occurred	d due to the ca at the time, da	use(s) and manrate and place, an	ner as s d due te	lated. the cause(s	s)
	the thin 2 the mplei	Med	one)	and manner sta	tea.		29c. License							
1	1 × 100		29b. Signature and title of certifier	_					2/1		9d. Date signed (
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_	12		30. Name and address of person who	1,206.	Tumone	, Print) UN	rd.	saite	_#Z	091,	5-3-c	-11	NO 2	1093
8	Sta Regist		31. Date filed (Month, Day, Year) MAY 0 4	A 40 11 11 11 11 11 11 11 11 11 11 11 11 11	r's Signature	Lieu	N E							

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	p	For State Certificate of Death	Reg. No 2. Date of Death).	3. Time of Death
Physicia		Decedent's Name (First, Middle, Last) Decedent's Name (First, Middle, Last) Decedent's Name (First, Middle, Last)	Month Day April 30, 2007	y Year	1200 hrs
ledical Exami		a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat		4c. County of Death Harford)
		311 Forest Valley Drive Forest Hill 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr	rs. 8. Date of Birth(Mi	M/DD/YYYY) 9. Bir	thplace (State or
Funeral Director		217-34-9767 12 M 2 F 68 Yrs. Months Days Hours Min	April 13	3,1939 Foreig	untry) MD
ý		Jsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
J 10w any		MD Harford Forest Hill			1 Yes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. In if I friend T is marked other than "natural", or items 23a or 28a-f show min. If then 2 is an arted other than "had well as the most be notified at once.	Director	10e. Street and Number 10f. Zip Code	10g. C	Citizen of What Cou	ntry?
the Ma a or 2	ä	311 Forest Valley Dr. 21050		USA	rican Indian, Black,
with ms 23;	eral	11. Marital Status 12. Was Decedent Ever in U.S. Armod Excess 13. Was Decedent of Hispanic Origin? (3) If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	White, etc.	rican Indian, Black,
death or ite	Funeral	1 Never Married 2 Married 1 Yes 2 No		Specify: W	rite.
hours after 'natural''.	ক্র	3 MWidowed 4 Divorced in road and partial of Decedent's Usual Occupation (Give kind o	of work done	b. Kind of Business	/Industry
2 hours afte "natural".	ted	Flementary/Secondary (0-12) College (1-4 or 5+)	etired)	T 200	
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. In proportant: If tien 27 is americed other than 'hintry or other returnmatic event, the Medical, hintery or other returnmatic event, the Medical.	ខ្ល	17. Father's Name (First, Middle, Last)	me (First, Middle, Maio	en Surname)	
121 1 be fi ental 1 arked	a a	19a. Informal t's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of	or Rural Route Number	r, City or Town, Stat	te, Zip Code)
D 21 should and Me 7 is ma	٤	194 Maria Maria Maria Maria Maria Dal Dal Dal Dal Dal Dal Dal Dal Dal Da	lesville.	MD 21	132
mnd 2 sho ealth and tem 27 is		20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20	Oc. Location - City o	or Town, State
Baltimore, sermit. Pages I ar Department of He Important: If ite		1 X Burial 2 Cremation 3 Removal from State Cremation of the place Mon Rock &	5/4/07/8	Elkrida	c.mo
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Balti permit. Departm Imports		Vinley 1 30 JOSTALL Enos Fine walch	a poly (row	ationSer	Approximate Interva
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause/on/each line.			Between Onset and Death
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		or condition resulting in death) Due to (or as a consequence of):	· .		
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	ımine	cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of):			
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Vita ysicia this ce	D C	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Outer4 N		Residence 6 00	ther: Scene
of ing Ph After	unerai	27. Manner of Death 28a. Date of Injury FOUND: 28b. Time of Injury FOUND: 28c. Injury at Work? 1 Natural 5 Pending	Subject involved	ved in residence	ce fire
sion trend death.	the state	2 Accident Pending Investigation Apr 30, 2007 1155 hrs Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (St	reet and Number or	r Rural Route Number, C
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed the Puneral Director: After this certificate has been signed by the attending physician and the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the fune Modical Certification:	3 Suicide 6 Could not be determined (Specify) Single Family	or Town, Sta 311 Forest Vali	ate) ley Drive, Forest	Hill, MD
C ospita		4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	, and due to the cause	(s) and manner as	stated.
E H.	plete	Certifying Physician: To the best of my knowledge, death occurred at the control of the control	rred at the time, date a	ind place, and doe t	
5 5 5		and manner states.		29d. Date signed	Atanth Day Voor
Division of To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A	No.				(MOTILIT, Day, real)
To th within	noo Ma	29b. Signature and title of certifier 29c. License number O.C.M.E.		May 1, 2007	(Monitri, Day, Fear)

31. Date filed (Month, Day, Year) State Registrar

Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** H WHONH HURVAT 320 0 26 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ndel Ann C PO ler 1 Year | If Under 2 Hnno edical Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 336-05-806 April 17 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Examiner must be notified at 1 Nes 2 No Directo $\mathcal{M}\mathcal{D}$ 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 14. Race - American Indian, or items 23a 126 Brent by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 De rés 2 No Army if Yes, Give Year or Dates: WW. II 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: 3altimore, Maryland 21215-0036 3 Widowed 4 □ Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the M. College (1-4or 5+) Elementary/Secondary (0-12) maintenance Maintenaine & 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Horva ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) bristin Arnold MD 21019 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-8-07 4 ☐ Donation 5 ☐ Other (Specify) Vetro Crematory 21. Signa per Funeral Service Licenses 22. Name and Address of Facility AM 1232 Midvaller 23a. Partí. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ω /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy 22 1□ Yes or Attending Physiclan: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation s after deau, ral Director: Aftr 1 Natural 1 TYes 2 □ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined within 24 hours a To the Funeral I To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier pered cause of death (Item 23a) (Type, Prin JX

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

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2007

32. Poistrar's Signature

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Jason Ricardo Harr	1- F	or State	Certificate	of Death		Reg. No	D	To Time of Dooth
Physician/ Medical Examine	1.	Decedent's Name (First, Middle,Last)	ardo Harri	50n		Date of Death Month Day May 1, 2007	Year 4c. County of Deat	3. Time of Death 1430 hrs
# ** *	48	. Facility Name (if not institution, give	street and number)	4b. City, To	own, or Location of Death	Ţ	Baltimore Col	
	-	1218 Harwall Road Social Security Number 6. Se	x 7. Age (In yrs. last birthday		r 1 Year If Under 24Hrs.	8. Date of Birth(M	M/DD/YYYY) 9. Bii Forei	rthplace (State or
Funeral Director	2	13-94-9548	27	Yrs. Months	Days Hours Min.	Dec.31,		ountry) V d
w any		Sual Residence of Decedent Da. State 10b. County	10c. City, Town or Lo	ocation	<i>CO</i>			10d. Inside City Limits 1 Yes 2 No
the Maryland a or 28a-f show tifted at once.	11	De. Street and Number	UDI	10f. Zip	Code 7	10g. (Citizen of What Con	untry?
with the Pass 23a or be notifie	<u> </u>	218 Har W	Armod Forces?	Was Decede	nt of Hispanic Origin? (Spe y Cuban, Mexican, Puerto F	ecify Yes or No- Rican, etc.)	14. Race - Ame White, etc.	erican Indian, Black,
ter death	-		1 Yes 2 No	Yes 2	4.au	-ti dono 16	Specify: B	ack s/Industry
tours al		15. Decedent's Education (Specify o	nly highest grade completed) College (1-4 or 5+) 16a. Dec duri	edent's Usual ing most of wor	Occupation (Give kind of wrking life. DO NOT use retire		D. Killy of Education	4
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) 7. Father's Name (First, Middle, Last	O Ma	achir	18.Mother's Name	(First, Middle, Maid	rivate den Surname)	· Companies
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MD 21215-003 d 2 should be filed within the and Mental Hygiene in 27 is marked other it annual to core, the Mental Hygiene.	10 B	9a. Informant's Name/Relationship (arrison 12	Mailing Address	arwall Ro	d. Ba	to. Md	. 21201
Baltimore, ME permit. Pages and 2 s Department of Health a Important. If item 27 injury or other traum		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State 20b. Place of D crematory	Disposition (Na or other place	me of cemetery, 5/9	Date 2 2	Bulto	. Md.
Baltimore, permit. Pages la Department of He Important: l'ite	1	4 Donation 5 Other Specification of Funeral Service Lice	y: h (Y) q	22. Name and 305ep	Address of Facility	5 Fyre	ral Hor	ne, P.A.
M គ ភ គ គ Physician	+	23a. Far I. Enter the all ease, or compail re. List only one cause on a	aplications that caused the death. Do not e	2222 enter the mode	of dying, such as cardiac of	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and Death
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O.O. Box that the death med by the att		Part II. Other significant condition	s contributing to death but not resulting	in the underlyi	ing cause given in Part I.		2 No 3	Probably 4 🗹 Unknown
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IVISION OF Attend after death Director:	tifica	2 Accident Investign 3 Suicide 6 X Could determ	not be 28e. Place of Injury - At home, fa	rm, street, fact	ory, office building, etc.	1218 Hart	tate) Well Rd. G	wynn Oak, MD
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funcerl Director: After this certificate or ompletely filled in by the funeral director, page	Medical Certification:	4 Homicide 29a. Certifier (Check only) Certifying Phy	sician: To the best of my knowledge, dea iner:On the basis of examination and/or in	ath occurred at	the time, date and place, a	nd due to the caus d at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
To the within To the comple	Medic	one) 2 Medical Exam 29b. Signature and title of certifier	and manner stated.		29c. License number		29d, Date signed	(MORKII, Day, real)
• V)		Tund of Del	Hall, mp		O.C.M.E.		May 2, 2007	
600		30. Name and accress 1 person v Pamela E. Southall, MI	who completed cause of death (Item 23a) Assistant Medical Examine	r 111 Pe	enn Street, Baltimore	, MD 21201		
0 4	State	De State Control Control	2007 32 Régistrar's Signature	ALGORAGE.	A STATE OF THE STA			
Regi		****		4				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav Year Elizabeth M. Hook April 28, 2007 7:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Summit Park Health Care Catonsville Baltimore 8. Date of Birth (Month, Day, Year) Country) Sept. 28,1912 Maryland If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 St F 94 Director 215-22-8286 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Ex miner must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 719 Maiden Choice Lane HR 311 21228 Pages 1 and 2 should be filed within 72 hours after death vnent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tyes 2K No. Specify: White þ Specify: 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Rusiness/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ (Unknown) Powe11 (Unknown) 19a. Informant's Name/Relationship (Type. Print) Personal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hedley Clark - Representative | 1 N. Charles Street, Suite 400; Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【☐ Cremation 3 Pemoval from State rematory 5-2-2007 Catonsville, Maryland 22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke Funeral Home of Catonsville, Inc. 5 Other (Specify) 4 ☐ Donation Metro Crematory 21. Signature of Funeral Service 1630 Edmondson Avenue; Catonsville se, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a: Part1, Enter the dise shock, or heart failur Immediate Cause and disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: IF FEMALE: 23b. Was decedent pregnant 12 months? 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 ment Month Day Year 5 ☐ Other (specify) 9□Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Completed 1 Tes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**8** No 1 ☐ Yes Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No the Funeral Director: mpletely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

14

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (tem 234) (Type, Print)

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32. Registrar's Signature

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MAY 0 4

Year)

2007

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Manth Year 2:00 AM Jackson 200 Herndon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Tewn, or Location of Death Examiner Battimore 8. Date of Birth (Month, Day, Year) 3 – 20 – 1922 6. Sex 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F Virginia 224-14-6319 85 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Maryland Director Dundalk Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 8101 Cornwall Road 21222 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black White, etc. 1XYes 2 No
If Yes, Give
Year or Dates: Navy 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify:White Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Coppers Company Elementary/Secondary (0-12) College (1-4or 5+) Machinist Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Callie Stanley Thomas Neal Herndon 19a. Informant's Name/Relationship (Type. Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance Herndon-Zingarelli 8101 Cornwall Rd Dundalk, Maryland 21222 Baltimóré, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery 5-4-07 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature Juneral Service License 22. Name and Address of Facility Joseph N. Zannino Jr. Funer 263 S. Conkling St. Balto. Funeral Home 23a. Partt. Enter the disea shock, or heart failure complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 051 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Rev Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the s 9☐Unknown 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performe death? 1 ☐ Yes 2 ☐ No certificate 2 X No Hospital or Attending Physician: 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident Injury 5 Pending 1 Yes 2 No investigation death. the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

VASILIADES

32. Registrar's Signature,

30. Name artd address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** A M Gwendolyn 28, Ε. April 2007 2:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Eastpoint Nursing and Rehabilitation Baltimore Dundalk If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M *XXF Dec. 30,1922 Director 218-09-9076 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f show 1 Yes 2 □ No Director N/A Baltimore Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. Street Imla Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. r than "natural", or iter the Medical Exeminer 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Never Worked N/A6th. Grade marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill f Health and Mental Hitem 27 is marked off Be Hill C. Flamm. Frederick Dora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Mason/Niece 1736 Melbourne Road Baltimore item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
eny injury or ot 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 05/02/2007 MD Metro Crematory Baltimore 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. 6224 Eastern Avenue Baltimore 21224 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Literary one cause on each line. Approximate Interval Between Onset and Death hero schrolic earl **Physician** disease or condition resulting in death) /Medical Due to (or as a Examiner herosclero si Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed anding physicism and use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by inteslina Hemon hall 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٥ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27 Manner of Death 28h. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending М 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 [Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ₩ 00/1150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MELITO M. TORRES, M.O. 441 S. ELLWOOD AUE, BALTO, MD 21224

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month; Day, Year)

Box 68760,

P.O. F

Division of Vital Records.

32. Rasirar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend 1, per MD, G867,5/4/07 TT Certificate of Death Reg. No. 200 1. Decedent's Name (First, Middle, Last)

Daniel Paul Jarrell 2. Date of Death 3. Time of Death Day Year Month **Physician** 2007 mas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital Baltimore Lit 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours **Director** 40 11/18/1966 218-84-4286 Maryland Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1 Yes 2 No Director Maryland Baltimore Dundalk the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or : any or other traumatic event, the Medical Examiner must be ruy or other traumatic event, the Medical Examiner must be ruy. Apt "E" 7819 W. Collingham Drive 21222 Funeral Α. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 2 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ို Daniel Marion Jarrell Anna Estelle Huber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Jarrell (Brother) 414 Riverside Drive Daniel _Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important; If it any injury or o once. 1 XBurial 2 □ Cremation 3 □ Removal from State 5/4 | 2007 Middle River, Maryland 4 □ Donation 5 □ Other (Specify) Hollv Hill Memorial Gårdens 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 21. Signature of Funeral Service Licensee PA Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cichail C. Jug Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a chisequence of): **Physician** day /Medical **Examiner** ineumonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Tetralogy burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician a the burial Physician/Medical attending pl IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? څ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No s certificate has b irector, page 2 sl 24a. Was an autopsy
performed?

1 Yes 2 Vo the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury n 24 hours after death.

ne Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 1,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 606 N. Wolfe St. , Baltmore, MD Treyor Ellison MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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2007

32. Resistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
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State of Maryland / Department of Health and Mental Hygiene
AMEND TIEM/5, perFH, Control of Weath
Reg. No. 1 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month **Physician** 02^{Day} 200^{Y-9}ai 9:32 Р. м Anna Estella Jans /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Harford County Bel Air | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Fore (Month, Day, Year) | Baltimore, MD. 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F 82 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland ind Mental Hygiene. s marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Maryland | Harford County Fallston 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1704 Bordeaux Court 21047 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: ₩.₩.II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Legal Secretary 12 n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Mental Important; if Item 27 is marked oth any Injury or other traument once. Be Stella Rackauckas ို Felix Capone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8216 Arrowhead Road Pikesville, Maryland 21208 Mr.William John Jans, III (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Feaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee 23a. Fall Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Be Completed by Physician/Medical been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 Ø No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy perform certificate 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 ☐ Nursing Home Specify) 1 ☐ Inpatient 2 【XER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral L the Hospital 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 841 death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of OSLER DRIVE SVITE 101 TOWNON JAMES EBELING MD 31. Date filed (Month, Day, trar's Signature Year) 32. State 04 2007 Registrar

ANNA, JANS

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with 1	s 23g	ā	11. Mantal Status	12. Was Decedent Even	n U.S.	13. Was	Decedent of Hisp	anic Origin	n? (Specit	fy Yes or No-	14. Race -	American Indian, Black	k,
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	endin use a	cia	past 12 months?	4 Pregnant at time of			er (Specify)		, -g,			,	
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Records, P.O. Box 6 The law requires that the death cer	been signed by the attendi hould be detached for use		Part II. Other significant condition	s contributing to death but r	not resulting	g in the un	derlying cause giv	ven in Par	t I.	23e. Did to	bacco use contrib	oute to the cause of dea	ath?
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a a a	certificate l ector, page	Ŝ.								1 Yes	2 No 1	✓ Yes 2	No
ion of Vital Records, tending Physician: The law required		Be	25. Was case referred to medical examiner?	Hospital:	4 50/0			Nihori -	Check only		5] au	
Phys.	After this uneral dir	P,	1 ✓ Yes 2 No 27. Manner of Death	i inpatient 2		Time of Inj			Nursing H		Residence 6	Other:	
— :=		崩	1 V Notural	28a. Date of Injury (Month, Day,Year)	200.	rine or inj		es 2		u. Describe i	tow injury occurre	d	
SiOI	ctor:	萬	2 Accident Pending	ation									-
Division	Dire Dire	Certification:	3 Suicide 6 Could n		At home, fa	ırm, street	, factory, office bu	ilding, etc	28	f. Location (S or Town, S		r or Rural Route Numb	er, City
Di To the Hospital	within 24 hours after death To the Funeral Director: completely filled in by the	ē	4 Homicide determine 29a. Certifier	(0,000))									I
e Ho	n 24 ne Fu oletely	g	(Check only 1 Certifying Phys	ician: To the best of my knower:On the basis of examination	vledge, dea	ath occurre	ed at the time, dat	e and plac	ce, and du	e to the caus	e(s) and manner a	as stated.	
To the	To the	Medical		and manner stated.	on and/or II	., resugant			- at UI	o unio, date			
		Σ	29b. Signature and title of certifier	1/000			29c. License					d (Month, Day, Year)	
			Card ?	Hella			O.C.N	1. ⊏.			April 26, 20	07	
	7		30. Name and address of person wh			_		1311					
-	/			tant Medical Examine	r 111	Penn S	treet, Baltimo	re, MD	21201				
			31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	break	PH						
		trar	MAY 0 4 20	11 / FW.01 a.	17 m . 17	12.7 THE REST A	- Marie 1						,

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, G867, 5/16/07 TT Certificate of Death 1 - For Amend #17, perFH, Certificate of Death Reg. No. 2. Date of Death Physician Mon /Medical **k**ocation of Death 4c. County of Death **Examiner** N-H If Under if Under 1 Year yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Days 2 F Hours Opuntay) Yrs Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ZYes 2 No Director 10f. Zip Code 10g. Citizen of What Opuntry? Funeral Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working , life. DO NOT/use/retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "rn any Injury or other transment." Oollege (1-Aor 5+) 17. Father's Name (First, Middle, Last) Phillip G. Kane 20a. Method of Disposition 3 Removal from State Buriai 2 ☐ Cremation 4 Donation 5 Dother (Specify) Approximate interval Between Onset and Death 23a. Part1. Eher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 0 gre disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has autopsy perform Division or Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Sther (Specify) HOSpice မ 1 Yes 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2,2007 5005

State Registrar

31. Date filed (Month, Day, Ye

Year

0

person who completed cause of death (Item 23a) (Type, Print)

6701

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ()4 30^{Day} 2007 **Physician** KELLY 03:43am^M JULIUS /Medical 4a. Facility Name (If not institution, give street and number)
Washington Adventist Hospital 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07-11-1924 Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Months Days Hours 1 XM 2 □ F 82 Washington, DC 578-22-4428 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1⊠Yes 2□No n/a Washington Director DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20017 751 Faraday Place NE Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyres 2 No If Yes, Give Year or Dates:1943—1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Gov't College (1-4or 5+) Elementary/Secondary (0-12) Supervisor Pages 1 and 2 should be filed nent of Health and Mental Hygi ant: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jackson Be Amanda Kelly William ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 751 Faraday Place NE Washington, DC 20017 19a. Informant's Name/Relationship (Type. Print) wife Dorothy C. Kelly 20c. Location - City or Town, State Suitland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 05-05-2007 1 Numal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lincoln Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bianchi 814 Upshur St NW Wash, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical RESPIRATORY FAILURE Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed JUE O WOUL the burial-tran Division or Vital Records, P.O. Box 68760, attending physician for use as the buria ARDIAC RRHY Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 27 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2XNo 1X Inpatient ို After this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

Chandra Korapati, MD 7207 B hanover Pkwy, Greenbelt, MD 20770

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD52855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** MAY Vera Elizabeth Krebs 01 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 7. Age (he vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Sex 5. Social Security Number **Funeral** Months Hours Days 1 □ M 2 😾 F 78 11/3/1928 Director <u> 217-24-6971</u> MD Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐Yes 2 ☑ No Howard Elkridge Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6220 Old Washington 21075 Rd. USA 4. Race Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian, Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) marked other than Elementary/Secondary (0-12) Stereo Speakers 6 Factory Worker permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important: If item 27 is marked othe any injury or other trainment. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ Wilmer Upton Ellen Birmingham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathy Dougherty / Daughter 6220 Old Washington Rd., Elkridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 5/3/2007 Catonsville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gary L. Kaufman Funeral Home at MMP, 7250 Washington Blvd., Elkridge, MD 23a. P.rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final disease or condition resulting in death) **Physician** tracero /Medical Due to (or as a consequence of) Examiner Sequentially flet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed physician and Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 □Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown O 9 Unknown Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No has The 1∐ Yes Vita Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 3□ DOA 2 TER/Outpatient Certification: To or 27. Manper of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury Division or Attending 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 1 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie P20556 2007 21229. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caton Ave Baltimore sbeth 7 DVel 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 1 1 7

Approximate Intervat Between Onset and Death

Day

24b. Were autopsy tindings available

23e. Did tobacco use contribute to the cause of death?

2 No 3 Probably

1 ☐ Yes

24a. Was an

Year

	•	1 - State Registrar				•	tificate	e of I	Death		Rei	a. No.	001	; , , , , ,
Physician /Medica		1. Decedent's Nam			Ko	\\					2. Date of Death Month		accit	3. Time of Death
Examine		4a. Facility Name ?		n, give street and nu	1	\			Location of				unty of Death	ove.
Funeral Director		5. Social Security N 214-01-8	299	6. Sex 1 ☐ M 2 💢 F	7. Age (In	yrs. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, 04/25/19		Coun	lace (State or Foreigr try) 1D
ehow	5	Usual Residence o	10b. County	INODE		c. City, Town or Lo							1	0d. Inside City Limits

Directo

Funeral

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Completed

Be

oriant: if item 27 is marked other than "natural", or iteme 23a or 28a-f el injury or other treumatic event, the Medical Examinar must be notified permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. important: if item 27 is marked other than "natural, or item any injury or other treumatic event, the Medical Examination DRE.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

ettending physician and for use as the burial-transit death certificate be executed

signed by the e

After this certificete hes been signe funeral director, page 2 should be

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Be Completed Certification: To Medical

BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 USA 8516 GREENS LANE Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **PROPRIETOR** RETAIL 5 & DIME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **BLUM** BENJAMIN IDA 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOWARD KOHN / SON 8516 GREENS LANE, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
BETH JACOB ANSHE
VESHEAR CONGREGATION 05/03/2007 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mett 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of) Due to (or as a consequence ot): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown

				performed?	death? 1 Yes 2 No							
25. Was case reterred to medical		26. Place of Death (Check only one)										
examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatient 2	PER/Outpatient 3□	Home 5 ☐ Residence 6	Other (Specify)								
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigatio		28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury	occurred							
3 Suicide 6 Could not b 4 Homicide determined			ory, office	office 28t. Location (Street and Number City or Town, State)								
29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	nysician: To the best of my kn miner: On the basis of examinand manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date and plaction, in my opinion, death occ	e, and due to the cause(s) a surred at the time, date and p	and manner as stated. stace, and due to the cause(s)							

29b.	Signature	and	title	of	certif	iei
	. ()				-	Г

29c. License number H0055644

29d. Date signed (Month, Day, Year) 70006 5 May

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) old Court Rd Randallstown MO 5401

State Registrar 31. Date tiled (Month, Day, Year)



DHMH 17 Rev 1/200

To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

DHMH 17 Rev 1/2001

	•	For State Registrar	State of Ma			artment of F tificate of		nd Mer		ene 0 0 7	14452	
Physicia	an	Decedent's Name (First, Middle, La MARY H. LOCKI	•						Date of Death Month	Day Year	3. Time of Death	
/Medic	al	4a. Facility Name (If not institution, gi				4b. City, Town, o	r Location of I		IAY 01	2007 4c. County of Dea	6:15A M	
Examin	er	HCR MANORCARE		NEY		TOWS		Doutin		BALTIM		
Funeral Director			Sex 1□M 2X F	91	thday) Yrs.	If Under 1 Year Months Days	If Under 24	4 Hrs. 8. Min. 1	Date of Birth (Month, Day, Y	(ear) 9. Bir	thplace (State or Foreign buntry) INESSEE	
pue *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Lo	cation					10d. Inside City Limits	
Maryle fisho	lor	MD BALTI	MORE	•	WS						1 ☐ Yes 2 ☐ No	
r 28e-f	Director	10e. Street and Number				10f. Zip Code			100	g. Citizen of What C	1	
23e d	aiD	111 WEST ROA	D				204			USA		
72 hours after death with the Maryland 72 hours after death with the Maryland neturel; or Items 23e or 28e-f show dical Examination and the invitited at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent If Armed Forces? 1 Yes 27 N If Yes, Give Year or Dates:		'	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 No	ispanic Origir an, Mexican, f Specify:	n? (Specify Puerto Rica	Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK		
72 hou		15. Decedent's E	ducation	16a.	Deced	lent's Usual Occup	ation	of working	16	6b. Kind of Business	/Industry	
- 3	Completed	Elementary/Secondary (0-12)	College (1-4or 5		life. L	DO NOT use retired	d)			W=5.43	· -	
be filed within 72 ho Ital Hygiene. Id other than "netui event, I'lly Medical	e Co	12TH 17. Father's Name (First, Middle, Las	t)		MEI	DICAL SI			rst. Middle, Ma	MEDICA	ΥL	
id be ental ked o	To Be	JOHN WESLEY							BOHAN			
as I and 2 should be filed within set I and 2 should be filed within of Health and Manlal Hygiene. I filem 27 is marked other than rother traumatic event, I'm M.	-	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailin	g Address (Street	and Number	or Rural Ro	ute Number, (City or Town, State,	Zip Code)	
and 2 eaith m 27 i		CLARA HAMMOND	/ NIECE				ORK RI	200000	_	ORE, MD		
Pag nent ent: I		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Special Control of Control		MD V	y cren ETI	sition (Name of natory or other plac ERANS CI ON FORES	EM. 5	Date 5 / 0 7 /		Oc. Location - City or OWINGS	Town, State MILLS, MD	
permit. Departr Importe any inj		21. Signature of Tyneral Service Lice	insee A, A	avr		Name and Addre					ME 21207 MORE, MD	
Physician /Medical		23a. Par1. Exter the disease, or construct, heart failure. List only immediate ause (Final disease condition resuling in death)	a Debi	lity		er the mode of dyin	g, such as ca	ardiac or re	spiratory arres	t,	Approximate Interval Between Onset and Death	
Examiner			Due to (or as a	a conse uence d	of):							
D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as t	з вопендинпес	if):							
cate be executed physician and it the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to /or on	consequence	-f\.							
be ex ictan burial	ai E		. Due to (or as a	consequence (JI).							
phys the	edicai		d									
The law requires that the death certific that has been signed by the attending page 2 should be detached for use as it	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ √0 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		Ectopic pregnancy Other (specify)				23d. Date of de Month	livery Day Year	
quires that n signed build be deta	by	Part II. Other significant conditions	contributing to death bu	it not resulting in	the ur	nderlying cause giv	en in Part I.		23e. Did toba 1 ☐ Yes	1	o the cause of death?	
The law requir sate has been si page 2 should	Completed								24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of	
icien: T	Bec	25. Was case referred to medical examiner?							heck only one)			
ohysiu this cr	ဥ	1 ☐ Yes 2 Delto	Hospital:				4 A Trursi	-		ce 6 ☐Other (Spe	cify)	
ding F h. After funer	tion:	27. Manner of Death 1 SNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day		ime ot njury	Wor	yat k? Yes 2 ∐No		Describe now	injury occurred		
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DHMH 17 Rev 1/2001

Divisio	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification
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			State of Maryland / Departm			•	
			FOI	cate of Death	, ,	. No. 2 1 1 7	14453
Ī	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	MAKINA LEE	City, Town, or Location of Death	APRIL	30 2007 4c. County of Death	9:30P ^M
	Examin	er	MILLENIUM FAYETTE HEALTH & REHAB		CITY	N/A	
	Funeral		10M CEF	Under 1 Year If Under 24 Hrs. nths Days Hours Min.	8. Date of Birth	9. Birth	place (State or Foreign intry)
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	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		10a. State 10b. County 10c. City, Town or Location MD N/A BALTIN	MORE CITY			10d. Inside City Limits
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Items 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Director	N/A BALITE				1 X es 2 No
	with the a or 2 the not	Dir	10e. Street and Number 1305 W. SARATOGA STREET	Of. Zip Code	10g	. Citizen of What Cou	intry?
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j	12 should be filed within h and Mental Hygiene. 7 Is marked other than traumatic event, the Me	ဥ		dress (Street and Number or Rura	E WINST		in Code)
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ני ק			20a. Method of Disposition 1	(Name of		c. Location - City or T	
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ם מ	permit. Page Department of Important: If any injury or once.			ne and Address of Facility HO' 00 LIBERTY HE		NERAL HO	
			23a. Part. Effier the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.			<u> </u>	Approximate
	Physician		Immediate Cause (Final				Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				1 00/6
i	4 8 8	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	tear faile	N.	-	27
	outed id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	V			
Ş	be executed sician and burial-transit						
	res that the death certificate be exigned by the attending physician be detached for use as the burial	dical					
S	nding use as	sician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of deliv	/erv
5	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	pic pregnancy er (specify)		Month	Day Year
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	The lay te has age 2	omo	They may		autopsy performe	prior to co	ompletion of cause of
3	ctor, p	Be C	25. Was case referred to medical	26. Place of Death		1110 112163	2010
5	Physic this co	၉	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3			ce 6 □Other (Spec	ify)
5	h. After funer	tion:	27. Manner → Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Month, Day Year) M	Work?	28d. Describe how	injury occurred	
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2	ital or irs afte ral Dir led in	Cert			City or Town, S		
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier (Check only one) 1	urred at the time, date and place, gation, in my opinion, death occuri	and due to the cau red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the Compile	Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month	, Day, Year)
	1		M/2	125344		13/0)	
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	(G.)	Rn-	4.0 1.	247
ş .	∑ Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature	s rong kd	12450	m) or	
	Registra		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) MAY 0 4 2007	Consultation of the Consul			

07-03320 Richa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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S. Soos Recurly Number C. See See C. See		4a.	Facility Name (if not institution, give street and harmon)			1, 2007		of Death	:1	
The state of the	Y	5. 3	Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Min			Foreign		
MD Howard Countries State of Annual Country State of State of Annual Country State of State of Annual Country State of State of Annual Country State of State of Annual Country State of State of Annual Country State			ual Residence of Decedent a. State 10b. County 10c. City, Town or Location					- 1		
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20. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory artest, shock in how. Between Onset a Be	ment of He tant: If ite or other to		Burial 2 X Cremation 3 Removal from State Metro Crem 4 Donation 5 Other Specify:	natory Inc	Witzke	Fune	ral H	omes,	Inc.	
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Wind Contract Co			Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
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Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, ND 21201	T iv I io	Me	29b. Signature and title of certifier Mung Grasself MB	1	er ————				, Day, , oar)	
	H			Penn Street, Baltim	ore, MD 21	201				

			For State Registrar		-	Pertificate of			Reg. No.	2007	1445
	Physici /Medic	_	Decedent's Name (First, Middle, William	Last)		Lucich		2. Date of De Month May	Day	07	3. Time of Death 16:04 P ^M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Dea	ath	4c. Co	ounty of Death		
			6800 Woodrow			Dunda				altimo	
L	Funeral Director		214-44-0313	. Sex 7. Age	(In yrs. last birthe	Months Days	If Under 24 Hr Hours Mir		rth ay, Year) 22 , 194.	1 Cour	place (State or Foreign ntry) Yland
	and *	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				1.	10d. Inside City Limits
	faryla sho ed at	ō	Maryland Balti		Duno						1 ∐Yes 2 ∐ X No
	the N 28a-	rect	10e. Street and Number		20	10f. Zip Code			10a. Citize	n of What Cou	ntry?
	3a or	Funeral Director	6800 Woodrow Ave	nue			224		US		
	ms 2;	Jera	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Decedent of H If Yes, specify Cub		(Specify Yes or N		. Race - Americ	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 🛣 No		erto Hican, etc.)		Black, White, pecify: Wh	etc. ite
2-0	72 hor	ted	15. Decedent's	Education	16a. D	ecedent's Usual Occup	pation	orkina	16b. Kind	of Business/In	dustry
21	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	Give kind of work done fe. DO NOT use retire	d)	roiking			
2	filed with Hygiene. ther than	S	12 years		.t	Recycler				notive	
and	tal do	Be	17. Father's Name (First, Middle, La Stephan Lucich	nst)			Billie	ame (First, Middle	e, Maiden Su	urna m e)	
Ž	s 1 and 2 should be filed within f Health and Mental Hygiene. tem 27 is marked other than other traumatic event, the M	2	19a. Informant's Name/Relationship	(Type Print)	10h A	failing Address (Street			har City or T	Town State 7	n Corto)
Ma	d2: thai thai 7 is trau		Barbara Lucich	Wife	1	00 Woodrow					1224
	Health tem 27 l		20a. Method of Disposition	MITE		isposition (Name of crematory or other plan		Date		tion - City or To	
Ω	ages ent of nt: If It		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐Removal from State		v Crematory or other play	11/1	3,2007	Balti	imore C	ity, MD.
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service Li		241,120	22. Name and Address Connelly F 7110 Solle		Home Of	Dunda l	Lk,P.A.	1222
	-		23a. Part1. Enter the disease, or construct, or heart failure. List or	omplications that caused t	the death. Do not	enter the mode of dying	ng, such as cardi	iac or respiratory a	arrest,	ے ، تعلق و عدل	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a. Meto	r Stort	2 Blad					Onset and Death
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D.		-e	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	consequence of)	:					
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68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	ledical		d							
	ng pt		IF FEMALE:								
Вох	leath certifica attending pt I for use as t	jan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1 ☐ Live birth 2	2 Fetal death	3 ☐ Ectopic pregnanc	y		230	d. Date of delive Month	ery Day Year
	t the de by the a tached f	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	time of death	5 ☐ Other (specify) _				11101111	bay rour
P.0	that the ed by detac	by Physician/N	Part II. Other significant condition	s contributing to death but	t not resulting in the	ne underlying cause giv	ven in Part I.	23e. Did	tobacco use	contribute to t	the cause of death?
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٥	ding Phys After this funeral di		27. Manner of Death	28a. Date of Injury (Month, Day	y 28b. Tin Year) Inju	ne of 28c. Injur		28d. Describe			<i>"</i>
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Division or Vital Records,	i or Atter after de Directe	ertific	3 Suicide 6 Could no 4 Homicide determin		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	(Check only 2 Medical Ex	Physician: To the best of caminer: On the basis of	examination and/	death occurred at the ti or investigation, in my	me, date and pla opinion, death oc	ace, and due to the courred at the time	e cause(s) ar	nd manner as s lace, and due t	stated.
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	/		30. Name and address of person w	no completed cause of do	ath (Item 23a) /Ti	rne Print)	0 - 1 4	n Are		- 1-1	2200
	5			VILL MD	JHBN	5200	Sacker	n Are	MFL	Bldo	Bailtonne
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State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Etta Lee Lahner 01-/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Franklin Sa 5. Social Security Number Rosedale Inder 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Baltimore Hospital 6. Sex 9. Birthplace (State or Foreign 1 M 2 F **Funeral** Hours Year) 212-48-4755 58 Director 1948 Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Examiner must be 7614 Philadelphia Road 21237 or Items 23a U.S.A. s 1 and 2 should be filed within 72 hours after death vor thealth and Mental Hygiene.
The Azis marked other than "natural", or Items 23a richer traumatic event, the Medical Examiner mus 31. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Specify þ 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Years <u>Housewife</u> Her own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald Lahner Phyllis Louise Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Quigley 308 Hamilton Avenue Baltimore, MD 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Important: If any Injury once. Parkwood Cemetery 5/4/07 4 ☐ Donation 5 ☐ Other (Specify) Parkville, MD 21. Signature of June 1 Service Licensee 22. Name and Address of Facility
Miller-Dippel Funeral Home, Inc.
6415 Belair Road Baltimore, MD 8/1 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Coronary Artery Disease 1600 Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician ar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 by Physician/Medical attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has performed? 'es 2 \ \ \ No certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ¶Nes 2□ No Hospital: P 1 Inpatient 2 NER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 □ Could not be 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide n 24 hou₁。 the Funeral Dir 🎜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 ho

To the Function 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 Name and address of person who completed cause of death (Item 23a) (Type, Print) Square Drive Baltimore

State

Registrar

31. Date filed (Month, Day,

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2007

Fistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Month Year George William Mudd 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUARE HOSPILA ose dAle MORE 8. Date of Birth (Month, Day, Year 04/29/1931 5. Social Security Number 7. Age (In yrs. last birthday) if Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours XXM 2□F 253-46-7364 76 Director Georgia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ∐Yes 2√TXNo Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 U.S.A. 6925 University Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? MXYes 2□ No 1949— If Yes, Give Year or Dates: 1961 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married XX Married r than "natural", or i Maryland 21215-0036 1 ☐ Yes XXNo þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If Item 27 Is marked other this amy injury or other traumatic event, the once. 12 Mechanic Automobile 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Doris Ann Bradley James D. Mudd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 677 Kittendale Circle, Baltimore, Maryland 21220 Kelly Bolch (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Bayview Crematory, Inc. 05/07/2007 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 21 ognikare of Funcial Berry 23a. Part1. En shock, of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Immedia Cause (Final Due to (or as a consequence of): **Physician** DISTRESS diseas r condition resulting in death) Acule /Medical **Examiner** ung CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (unus a consequence of): Examine sician and burial-transit The law requires that the death certificate be executed LOPD Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical as attending | for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? ours after death. eral Director: After this certification by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

To the Hospital or Attending Physician: within 24 hours a

To the Funeral I

completely filled

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State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANK CATheRINE

and manner stated.

SEUARE DR. BAITIMORE

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

29c. License number

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 26 per verb 8867 5-4-07 vt
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day ANTHONY J. MASTROCOLA 06:25PM MAY 01. 2007 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Towson Center Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. May 1 Day, Year) 71 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Months Mary land 1 X M 2 □ F 36 218-70-8252 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 ☐ No Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number USA 21214 5607 Tramore Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Never Married 2 ☐ Married White 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lawn Care Service Landscaper 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony F. Mastrocola Marlene C. Augustyniak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) father 5607 Tramore Road-Baltimore, Maryland 21214 Anthony F. Mastrocola 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition More randory Memorial 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State May 5,2007 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
EVANS FUNERAL CHAPEL 8800 Harford Road Parkville, Maryland 21234 AND CREMATION SERVICES 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YEARS METASTATIC COLON CANCER Due to (or as a consequence of): DAYS ACUTE RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FFMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy

Physician /Medical Examiner Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed

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/Medical

Examiner

Funeral

Director

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Baltimore, Maryland 21215-0036

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27. Manner of Death 1 Manual 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ry occurred
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State Registrar

of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address

> D. 7601 OSLER DRIVE TOWSON, MARYLAND

29c. License numbe

D0063974

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

	State of Maryland / Department of Health and Mental Hygiene								
		1 - State Registrar		Certificate of Death	Reg. No.				
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ath cert	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)	2	23d. Date of delivery Month Day Year			
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Hospitel or 24 hours afte Funeral Dir letely filled in	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knowledge iner: On the basis of examination an and manner stated.	e, death occurred at the time, date and place and occurred at the time, date and place and/or investigation, in my opinion, death occurred.	a, and due to the cause(s) arred at the time, date and	and manner as stated. place, and due to the cause(s)			
To the within 2 To the Complet	Med	29b. Signature and titla of certifier 29c. License number 29d. Date signed (Month. I							
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β'		30. Name and address of person who co	ompleted cause of death (Item 23a)	W Lambard St	+314 Dot.	Baltimore MD 21201			
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FFEMALE 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 3 Probably 4 Personant at time of death 5 Other (specify) 23d. Date of delivery Month Day Year 1 Ves 2 No 3 Probably 4 Proposition Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Proposition Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Proposition Part II. 1 Ves 2 No 3 Probably 4 Proposition Part II. 1 Ves 2 No 1	760	sicien buria	alE		,						
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29a. Certifier (Check only one) 29medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALVADOR SINCESTER 3001 Hops Pital Drive Charely May and May and Amandadadadadadadadadadadadadadadadadadad	<u> </u>	The ate h page	E O						perform	ned? deat	th?
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1011 Salvedor Silves Ter 3001 Hospital Drive Chevery, Maylord		n 24 he Fu pletel	edic	(Check only 2 Medical Ext	miner: On the basis of	examination and/or in	nvestigation, in my o	oinion, death or	ccurred at the time, da	ate and place, and	due to the cause(s)
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31. Date filed (Month, Day,

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30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)

Year)

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2007

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours -28-250 M 2□F Yrs. Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Important: If item 27 is marked other then "neture!" > 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. | 1.1. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Wa 21228 Completed by Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10. Driver Father's Name (First, Middle, Last) 18. Mether's Name (First, Middle, Maiden Sumame Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, -Wife SEFICAN all ivenotion 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date Burial 2 Cremation 3 Removal from State barrison torest 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licentee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** Lang Can codisease or condition resulting in death) 5130 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) the attending physicien end hed for use as the buriel-transit Hospital or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Dectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacço use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy certificate 2 10 1 ☐ Yes r: After this certification of tuneral director, 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: Medical Certification; To 1 Yes SONo 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending deeth. Director: / investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funerel Direct 4 - Homicide retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1744

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State

Registrar

31. Date filed (Month, Day, Year)

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2007

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes are

	1 - State Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No.	3. Time of Death	
Physician	Ellen E. Ogle		Month Day Yea MAY 01 201	- 44.00 444	
/Medical Examiner	4a. Facility Name (If not institution, give street and number) SAINT AGNES HOSPITA	4b. City, Town, or Location of Deal BALTIMORE			
Funeral Director	5. Social Security Number 217–12–3574 6. Sex 1 M 2 XF 87	hirthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min	. (Month, Day, Year)	Birthplace (State or Foreign Country) Iaryland	
show dat		wn or Location		10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
or 28a-f s be notified Directo	Maryland Baltimore Cator 10e. Street and Number	nsville 10f. Zip Code	10g. Citizen of What		
23a or st be		21228	USA	·	
be flied within 72 hours arer death with the invaryants that Hyghen. Had Hygher than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (fif Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 1 No Specify:	Specify Yes or No- rio Rican, etc.) 14. Race - Ar Black, Wi Specify:	merican Indian, hite, etc. White	
tal Hygiene d other than "natura svent, the Medical E	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Sa. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) Teacher	16b. Kind of Busines	·	
図 を 点	17. Father's Name (First, Middle, Last) James Edelen	18. Mother's Na	me (First, Middle, Maiden Surname) vieve Hilton	JII	
s marked o		9b. Mailing Address (Street and Number or F		a. Zip Code)	
if Health and Mer titem 27 is marke other traumatic		3628 Yolando Road; Ba			
O b-		of Disposition (Name of tery, crematory or other place)	Date 20c. Location - City	ř	
Department Important: If any Injury o once.	4 □ Donation 5 □ Other (Specify) Cres 21. Signature of Puperal Service Licensee	t Lawn Mem. Garden 5/	5/2007 Marriotts erling Ashton Sch	-	
Depa Impo any I	Mare Kell	Funeral Home of 1630 Edmondson A	Catonsville, Inc. venue; Catonsville	, MD 21228	
商	23a. Part1. Enter the isease, or complical in that caused the death. D shock, or heart failure. List only one cause on each line.		ac or respiratory arrest,	Approximate Interval Between Onset and Death	
/sician ledical	Immediate Cause (Final disease or condition resulting in death)	bulb ulcer		hours	
physician and six the burial-transit state burial-transit sedical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last C. Due to (or as a consequence)	6 00):		unknow	
d by the attending petached for use as Physician/Mec			23d. Date of a Month	delivery Day Year	
be d	Tarti. Other significant conditions continuating to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death? Probably 4 Munknown	
page 2			24a. Was an 24b. Were autopsy performed death		
certifi rector	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Impropriet 2 PR/V	Other:	eath (Check only one)		
uneral d	27. Manner of Death 1 Matural 5 □ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	Outpatient 3 □ DOA	Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred		
within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be C	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	28f. Location (Street and Number or City or Town, State)	Rural Route Number,		
thin 24 hour the Funer ampletely fill	29a. Certifier (Check only one) 1 **Medical Examiner: On the basis of examination and manner stated.	lge, death occurred at the time, date and place and/or investigation, in my opinion, death occ	ce, and due to the cause(s) and manner curred at the time, date and place, and c	as stated. due to the cause(s)	
within To th comp	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo	onth, Day, Year)	
	▶ Usendashi	P2065	May, o	1,2007	
0	30. Name and address of person who completed cause of death (Item 23a MAHMOUD Aldandashi	2	105P 21229		
	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1- 127011 11-1-1	0000		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per th 986/5-4-07 yr. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Marina Pereira 5:30 P M 4 28 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Towson Baltimore Gilchrist Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 3454F Director 216-47-7661 9/14/1932 El Salvador Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Lecation 10a. State 10b. County 10d Inside City Limits Director 1 ☐ Yes 2 ☑ No MD Baltimore Cockeysville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 105 Windy Falls Way Apt. J 21030 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: South American Specify: American Baltimore, Maryland 21215-0036 Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Residence 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francisco Barrera Marin Pereira ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

105 Windv Falls Way Apt. J Cockeys Ville, MD 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Infury or other trai 105 Windy Falls Way Apt. J Cecilia Diaz - daughter 20b. Place of Disposition (Name of cametery, crematory of other place)
Dulaney Valley
Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition Date 12 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Timonium, MD 21. Signature 22. Name and Address Certifi Alternatives Funeral & Cremetion Ctr.P.A. 2325 York Road Timonium, Maryland 21093 uneral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 9 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) physician the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 □No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier MATHON Muly: 00 D25207 April 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. Riley G. Ban (6701 N. Charles St. Balto Md

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 04/27 Year **Physician** Pettaway 2007 9:20 a^M Annie Louise /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cheverly P.G. P.G. Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 2 / 1 0 / 1 9 4 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 K F 65 578-56-9735 DC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: if lem 27 is marked other than "natural", or liams 272 and Injury or other traums? 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No MD P.G. Hyattsville Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3839 64th Avenue # 20784 408 U.S.A. by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: 3€3∜Vidowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Building Service Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Willie Stone, Sr. Alice Mae Mack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tonya P.Stewart/Daughter 3839 64th Ave.#308 Hyattsvile,MD 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Mt.Olivet Cemetery 05/05/07 Washington, DC 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ronald Taylor, II Funeral Hm 21. Signature of Funeral Service License 108 W.North Ave. Baltimore, MD 21217 ronald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to to as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence o Examiner The law requires that the death certificate be executed burial-transit ed by the ettending physicien and deteched for use as the burial-trar Duedo (or as a consequence Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 95 Unknown been signed by 23e. Did tobacco use contribute to the cause of greath? Part II. Other significant conditions contributing to death but not resulting in the upderlying cause given in Part II. pege 2 should be 1 ☐ Yes 2 ☐ No 3 🗌 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete hes autopsy performed? Yes 2**X** No 2 No 1 Tes Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient Certification; To 2 ER/Outpatient 3 DOA Sign filled in by the funeral . Date of Injury (Month, Day Year) 27. Manger of D ath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Injury 1 Natural 5 Pending 1 Yes 2 No death. I hours efter death. 2 Accident investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date soned (Month, Day, Year) 29c. License number 29b. Signature and title of certified 2 30. Name and addres of person also completed cause of death (Item 23a) (Type, Print) Dr. Cheverly Mid 2078S 31. Date file 1 (Month, Day, Year) 32. Registrar's Signature State 1 Registrar

State Registrar 29b, Signature and title of certifier

31. Date filed (Month)

MS PORW

29c. License number

Baltimore,

29d. Date signed (Month, Day, Year)

and manner stated.

MD

32. Registrar's Signature

4940 E

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RODA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep. State of Maryland / Dep. Ce	artment of Health and N rtificate of Death		ene . No. 11 D 7	14469
			Decedent's Name (First, Middle, Last)		2. Date of Death	k as at	3. Time of Death
t	Physici /Medio		Ruthie Wanda Patucci		Month April 15	Day Year	1:23 P ^M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
			7155 E. Baltimore Street	Baltimore		Baltin	nore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Bir	thplace (State or Foreign
	Director		431-52-6550 1□ M 2□XF 74 Yrs.		Dec. 23,		kansas
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	Maryl f sho ed at	5	N 1 1 D 1 1				1 □Yes 2 TNo
	the 1 28a- Potifi	Director	Maryland Baltimore Balt:	Lmore 10f. Zip Code	100	. Citizen of What Co	
	3a or		7155 E D-145 Church		1.03		,
	ms 2	Funeral	7155 E. Baltimore Street 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21224 Was Decedent of Hispanic Origin? (Spo	ecify Yes or No-	U.S.A. 14. Race - Ame	erican Indian,
و	after or ite		Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🋣 No Specify:	Rican, etc.)	Black, Whit	e, etc.
215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notitled at	l by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	TLIYES 200 NO Specify:		Specify: Wh	nite
ל	72 h 'natu dical	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16	b. Kind of Business	/Industry
7	vithin ne. han ' e Me	臣	Elementary/Secondary (0-12) College (1-4or 5+)			- 1.	
2	be filed within 72 hours after death with the Marylan Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		10th. Grade Key 17. Father's Name (First, Middle, Last)	Punch Operator	e (First, Middle, Mar	Banking	
ä		Be	Homer Crowley	Ida	t irst, middle, mai	Davis	
Maryland 2	12 should be filed vand Mental Hygie Is marked other traumatic event, th	မ		ng Address (Street and Number or Rura	al Boute Number. C		Zin Cade)
	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic			55 E. Baltimore ST			21224
ē,	item of Hei		20a. Method of Disposition 20b. Place of Dispo			c. Location - City or	Town, State
Ĕ	Pages nent of I int: If ite iry or o		1XXPurial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) Oaklawn	1	2007 В	altimore	MD
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee 22	2. Name and Address of Facility	C C	T	
n	8 3 2 6 8		1258	Charles S. Zeile 6224 Eastern Ave	r & son, nue Balt	inc.	21224
			23a. Part 1. En er the di ease o complications that caused the death. Do not en shoc in heart failu a lie only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest	,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	cema 4			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a construer of)	0			^ ^
	Lxammer	_	Sequentially list conditions, b.	NOONS			10 yelings
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	te sinal			10 years
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last C Due to (or as a consequence of):	JUN21011	.		10 georgs
2/00	cate be executed physician and the burial-transit	dical E	d				
g	requires that the death certificate een signed by the attending physi nould be detached for use as the	edi	0.				
ŏ	w requires that the death certific been signed by the attending f should be detached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the next 12 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy		23d. Date of del	ivery
	ed for	sicia	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐	Other (specify)		Month	Day Year
י ב	at the	Phy	9 D ONKHOWN				
Ś.	res the	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.			the cause of death?
cords	requi	ted			1 ☐ Yes	2 No 3 Pr	obably 4 Unknown
ě	The law ate has b	Completed			24a. Was an autopsy	prior to	topsy findings available completion of cause of
פ	icate icate r, pag				performer 1□ Yes 2	death? 1 ☐ Yes	2 □ No
=	siclar certif recto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ FB/Outpatient	26. Place of Death			
5	Physic this aral di	- T	1 ☐ Yes 2 ☐ No ☐ Inpatient 2 ☐ ER/Outpatier 27. Manner of Death 28a. Date of Injury 28b. Time o	4 Nursing Hol	me 5 2 Residence 28d. Describe how i	e 6 Other (Spe	cify)
5	th. :: Afte	tion	Altural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		injusy coccined	
2	Atter	ifice	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office		t and Number or Ru	ural Route Number,
5	tal or is after all Dil	Certification:	Sullaing, etc. (openly)		City or Town, S	state)	
	Hospi 4 hour Funer ely fill	edical	29a. Certifier (Check only (Check only and of the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in	n occurred at the time, date and place,	and due to the caus	se(s) and manner as	stated.
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 of the property of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 2 of the funeral director.	Med	and manner stated.	29c. License number			
	Z × Z	-	29b. Signature and title of certifier	@/J777	9 290.	Date signed (Monta	7/1 -1
	ìı		30. Name and address of person who completed cause of death (Item 23a) (Type,	V 7 C / C	1	0/1/	10)
	N		30. Name and address of person who completed cause of death (Item 23a) (Type,	Phy ladel sh	4 Ld	Bult	more MA
	Sta	te	31. Date filed (Month, Day, Year) 32. Signature		1	7 47 4	21837
1	Registr	ar	MAY 0 4 2007 Street &	and in			

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Eric Queen State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ ERIC EMMANUEL QUEEN **Medical Examiner** 2217 hrs Erik Emmanuel Queen April 30, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital **Baltimore** N/A 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** CounTARYLAND Directo Months Days Hours Min. 218-98-9830 1X M 2 24 06/06/1982 Usual Residence of Decedent any 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show N/A BALTIMORE CITY 1 X Yes 2 No MD death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2012 N. WOLFE STREET 21213 USA 238 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 5 2 X No Widowed Divorced f Yes, Give Year Yes 2 X No specify: BLACK Specify: ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) mit. Pages 1 and 2 should be filed within 72 partment of Health and Mental Hygiene portant: If item 27 is marked other than " the Medical Baltimore, MD 21215-0036 LABORER LABORER 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be FRANKLIN OUEEN GWENDOLYN WIGGINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GRAND-WIGGINS FANNIE L. BALTIMORE, MD 2121 te 20c. Location - City or Town, State WOLFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 X Burial 2 Cremation 3 crematory or other place) Removal from State MT. ZION CEMETERY 5/05/07 LANSDOWNE, 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AV, BALTIMORE. **Physician** the disease, or complications that caused the doubt. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear allure. List only one cause on each line Between Onset and /Medical a. Gunshot Wounds of Torso and Arm Death viate Cause (Final disease Examiner condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical attending physician a X AMENDED #1.pe UNPENDED .perME.g867.5/7/07 TT Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death Other (Specify) ned by the atte 1 Yes 2 No 9 Unknown 9 Hnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available ne has be autopsy prior to completion of cause of perform<u>ed?</u> death? this certificate h director, page? ✓ Yes 2 1 🗸 Yes No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi completely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 🗸 Yes Other: မ 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot Natura **FOUND** Yes 2 V No Pending Apr 30, 2007 0000 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 1900 block East Lafayette Avenue, Baltimore, MD determined (Specify) Local Street 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 1, 2007 ne and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Laron Locke MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) \$2. Registrar's Signature State Registrar

Univin 17 Rev 1/2001 **OCMF 2006**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Janet D. Rierson 8:15a^M April 26 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | March | 1,1939 Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 052-30-7575 New York 1 □ M 2 12 F 68 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 23a or 28a-f shov ust be notified at Director MD Baltimore Middle River 1 ☐ Yes ¾☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 10 Dundee Court 21220 USA permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mehal Hygene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must I Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🖾 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Verizon Data Clerk 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Meyer Lillian Bepler ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John L. Rierson / husband 10 Dundee Court Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State 4/30/07 Rossville MD 4 □ Donation / 5 □ Other (Specify) 22. Name and Address of Facility 300 Mace Ave.Balto. MD 21. Signature of Funeral Service Licenses Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CAUCER Lear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9□Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an pate has I autopsy performed? Yes 2 No 1 Division or Vital Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ٩ 1 | Inpatient 2 ER/Outpatient 3 DOA pre 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) NO 670/N. Charle St. Rolls Md 71205 6-Ben 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

07-03350

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene William Randall Certificate of Death 1- For State Reg. No. Registrar 3. Time of Death 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day May 2, 2007 Year 1545 hrs William Henry Randall III Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Bon Secours Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours Min 53 Jan. 9, 1954 216-62-2594 MD Director 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD Baltimore City 1 X Yes 2 No or items 23a or 28a-f show must be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21217 1651 N. Payson Street USA 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married Yes black Yes 2 X No specify: Specify f Yes. Give Year 4 XDivorced ment of Health and Mental Hygiene.
-tant: If item 27 is marked other than "natural",
or other traumatic event, the Medical Examiner. ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) lab technician Westinghouse Corp. 21215-0036 +5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Henry Randall Jr. Ruby Berry Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) timore, MD Travis Randall (son) 1651 N. Payson St., Baltimore, MD 21217 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State All County Cremation 5/5/2007 Sykesville, MD Donation 5 Other Specify 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Houge Haight Herbert .O. Box 195 Sykesvillel, MD 21784 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Death / Ir dical a right hip fracture with complications Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last g physician and the burial - transit executed Physician/Medical UNPENDED AMENDED Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Box 68760 23d. Date of delivery 23c. If ves, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death signed by the attending be detached for use as 1 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 No 3 Probably 4 ✔ Unknown þ Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available After this certificate has been funeral director, page 2 should prior to completion of cause of autopsy performed? death? 1 🗸 Yes 2 No ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be Other 4 examiner? DOA Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 1 Yes 28a. Date of Injury (Month Day, Year) 4/6/2007 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Subject fell UNKNOWN Natural Yes 2 V No Pending Director: 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) 7500 blk Ritchie Hwy, Glen Burnie, MD filled in determined (Specify) Sidewalk curb 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 3, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. 31. Date filed (Month, Day, Year) 32 Registrar's Signature

ORIGINAL

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month 1:50 John Anthony Stabile, Sr. May 3, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 327 Homberg Avenue Baltimore Essex 8. Date of Birth (Month, Day, Year) 05/26/1919 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1 🔀 🌿 2 🗆 F 215-03-9075 87 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 ☐ Yes 2 No Essex 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number 327 Homberg Avenue 21221 U.S.A. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐ Yes **XX**No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 XXIII Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Fire Department Repairman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pasquale Stabile Alesander Genelli 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara Stabile (Wife) 327 Homberg Avenue, Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. 05/14/2007 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. En the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Immediate ause (Final disease condition resulting ath) months Lung cancer Due to (o as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

or items 23a or 28a-f show aminer must be notified at

e filed within 72 hours after all Hygiene.

Other than "natural", or iter

the Medical

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division or Vital Records,

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permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trac

Director

Funeral

2

Completed

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Examine burial-transit physician s the burial Physician/Medical nding pl ned by the a þ certificate has been si rector, page 2 should Completed Be P Certification: ...d or Ath. ours after death. ral Director: Ath. in by the fire

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an

28d. Describe how injury occurred

1□ Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 ☐ Yes 2XXVo 27. Manner of Death 1X Natural

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only

2 Accident

3 ☐ Suicide

4 Homicide

TO Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier NB

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940

0-00 58893

Avenue AIII

29d. Date signed (Month, Day, Year) May 4, 2007

Baltimore, Maryland 21224

State Registrar

Medical

31. Date filed (Month, Day, Year)

Browner, MD



Eastern

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

To the Hospital of within 24 hours af To the Funeral D completely filled in

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 4a, b, 26 per doc 98/6, 2-7-08 vt. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SODE **Physician** 1:15 PM MARCIT 21,200/ /Medical (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 04/14/1954 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 K 1 F Baltimore, MD Director 216-46-3980 52 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show MD Baltimore Baltimore notified 1 XYes 2 □ No Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 6 must be 23a 751 Argonne Drive 21218 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2X No If Yes, Give Year or Dates: 1XX Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo þ 3 Widowed 4 Divorced 'natural', WHITE Completed th and Mental Hygiene.
7 Is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disable 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Sobel ٩ Joan Borowik 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 Is any injury or other trau once. Joan Kolobielsui / Mother 6710 Sherwood Road, Balitmore, Md 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Howard University March 21, 2007 Washington D C 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Serv 3821 14th Street N W Washington, D_C 20011 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, prure. List only one cause on each line. Part1. Enter the c shock, or heart fa Approximate Interval Between Onset and Death Immediate Cause Inal disease or condit n resulting in death) **Physician** Due to (or as a consequence of): immediate /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or deriving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARKINSON 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 1□ Yes 2XNo funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aresidence 6 Gallagher Medical 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Adult Day CAre 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural s after death.

Il Director; Al

d in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completely filled 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Mgnth, Day, Year) 037362 doress of person who completed cause of death (Item 23a) (Type, Print) 5 YORK ROAD Author SERAFI 1205 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 Registrar

Javid vvordeck	Sile	1- For State Registrar	f Maryland / Departm <i>Certifi</i> d	ent of Health and cate of Death	Mental Hygie	25	07-14475		
Physici		Decedent's Name (First, Middle,Last)		(1)		Reg. No. 2 C/C ate of Death onth Day Year	3. Time of Death		
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Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birth Months Days Hours Min. Foreign							
Director		218-64-8770	1 2 F	3 Yrs. Months Days	Hours Min.	turist 26,1953	Country) MD		
any	1	Usual Residence of Decedent							
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2121 could be fi d Mental I s marked	To E	19a. Informant's Name/Relationship (Typ			and Number or Rural F	Route Number, City or Town	, State, Zip Code)		
		Richard He	lbig 1	1773 Corm	an Bd. (Jakland, M	1D a1550		
Baltimore, permit. Pages I ar Department of Hes Important: If ite		20a. Method of Disposition 1 Burial 2 Cremation 3		of Disposition (Name of ceme tory or other place)	tery, Date		City or Town, State		
ti Pag tment rtant:		4 Donation 5 Other Specify	Met			07 Baltin	more, mD		
Baltimo permit. Page Department of Important:		21. Signatu Fun al Service License	Khanl	22. Name and Address of	a Midw	Mac D. To	18434 DA		
Physician		2.a. Part I. E. er the disease, or complice failure. List only one cause on each	ations that caused the death. Do n	ot enter the mode of dying, su	ich as cardiac or resp	iratory irrest, shock, or hear			
/Medical Examiner		Immediat Cause (Final disease a. Ci	rrhosis of the Liver				Between Onset and Death		
,		» Di	e to (or as a consequence of): ue to Alcohol Abuse						
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause							
Tall Sale	Examiner	(Disease or injury that initiated C	e to (or as a consequence of):						
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60, ate be exe hysician e burial -	cian/Medical		AMENDED						
6876C certificate nding phys	n/M	23b. Was decedent pregnant in the	23c. If yes, outcome of pregnancy		Ectopic pregnancy	23d. Date of d Month	elivery Day Year		
	sicia	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of death	5 Other (Specify)			Day 100		
that the des	Physi	Part II. Other significant conditions	9 Unknown	a in the underlying saves size	en in Doubl	23e. Did tobacco use contrib	who has the service of death O		
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ट = 5 ; ^ ⊄	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	Time of Injury 28c. Injury a	at Work? 28d. I	Describe how injury occurred	3		
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Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,	Sal	29a. Certifier 1 Certifying Physician	To the best of my knowledge, de	ath occurred at the time, date	and place, and due to	the cause(s) and manner a	s stated.		
To the How within 24 h	Medical	one) 2 Medical Examiner: O ar 29b. Signature and title of certifier	n the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and the basis of exa						
2	=	200. Orginature and title of certifier	/1/1	29c. License n		29d. Date signed April 23, 200	(Month, Day, Year)		
_ 2		30. Name and address of person who con	pleted cause of death (Item 23a)	O.C.IVI.					
				11 Penn Street, Baltim	ore, MD 21201				
		31. Date filed (Month, Day, Year)	32. Registrar's Signature	and a					
Regist	uali	MAY 0 4 2007	Branna St.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend 28f, perME, g868, 6/11/07 TT

Certificate of Control Contr 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2, 2007 Louis A. Sordo May 6:37PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery <u>Suburban Hospital</u> <u>Bethesda</u> If Under 1 Year | If Under 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Days 1 X M 2 □ F Yrs. Director 92 579-07-1811 August 25, 1914 Cuba Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show Hygiene. other than "natural", or Items 23a or 28a-f shov ent, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Bethesda 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7505 Granada Drive 20817 Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indi Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 No Specify: <u>გ</u> 3 Widowed 4 ☐ Divorced Specify: Cuban White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Veterinarian Self Employed permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If Item 27 is marked other any Injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Juan F. Sordo Maria Gonzalez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis A. Sordo, Jr./ Son 19619 Galway Bay Circle, Germantown, Maryland 20894 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 □ Cremation 3 □ Removal from State Gate May 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mopme disease or condition resulting in death) Respiratory Arrest /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Brain Hermiation Due to for as a consequence Ri attending physician and for use as the burial-transit Exami Subdural Hematoma Due to (or as a consequence of): Box 68760 Physician/Medical Fall IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic prognancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2☐No Ö 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s perform this certificate 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 1 XYes 2 No 2 o Sordo, funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director; After completely filled in by the funer. Division 5 ☐ Pending investigation 1 Natural March 30,2007 4:00 PM 1 ☐ Yes 2 X No 2 X Accident Fall At Home 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 7505 Granada Drive Bethesda 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signator and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D55620 May 3, 2007 10 d address of person who completed cause of death (Item 23a) (Type, Print) Zachary T. Levine, M.D. 4927 Auburn Avenue #100 Bethesda, Maryland 20814-2641 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

183

0415

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death AKA04 2007 Stephen S. Sella (Stephan S. Sella) 5:00 рм 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery 7505 Democracy Blvd. #A231 Bethesda If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days **1** M 2 □ F 219-08-5986 85 5/22/1921 Poland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Bethesda Montgomery 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 7505 Democracy Blvd. #A231 20817 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 D Yes 2 □ No If Yes, Give WWII Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+)

Businessman

Self Employed

18. Mother's Name (First, Middle, Maiden Surname)

Freda (unknown) Silverstein

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical.

Physician

Examiner

Funeral

Director

'natural", or items 23a or 28a-f show dical Examiner must be notified at

72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

\$

Completed

Be

ျှ

/Medical

10a. State

MD

17. Father's Name (First, Middle, Last)

Jacob Silverstein

19a. Informant's Name/Relationship (Type. Print)

burial-transi and law requires that the death certificate be execu physician the as attending asn ρ

signed by the a d be detached f peen cate has l certificate director, After this funeral death.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physiclan:

hours after

To the Funeral Director: completely filled in by the within 24 State

Registrar

31. Date filed (Month, Day, Year)

MAY 0 4 2007

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7505 Democracy Blvd. #A231 Bethesda, MD 20817 Sheila Ben-Dashan/companion 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Chesapeake Crematory 5/1/07 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Silver Spring, MD mo1356 Rapp Funeral& Crem. Svc933 Gist Av.20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 years a End Stare Ischemic Cardiomyopathy Due to (or as a consequence of): Coronary Artery Disease 30 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy pertormed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 1 ☐ Yes 2 No 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D54597 April 30, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Virginia Colliver, M.D. 6410 Rockledge Dr.#200 Bethesda, MD 20817

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Spriggs, Sr. **Physician** Melvin Month 6:25 AM April 2007 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Baltimore City Hospital N If Under 1 Year | If Under 24 Hrs. Months Davs Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days 216-50-0213 June 14, 1948 Director my Usual Residence of Decedent 10b. County 10c. City, Town or Location r 28a-f show notified at show 10d. Inside City Limits Funeral Director 1 ☐Yes 2 ☐ No MN Bal timore 10e. Street and Number 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be r Northshine USA 2603 21230 Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by 3 ☐ Widowed 4 ☐ Divorced Ancroca 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/ ndustry (Give kind of work done during most of working life. DO NQT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Laboner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print, Mary Louise ပ 19b. Mailing Address (Street and Number or Rural Royle Number, City or Town, State, Zip Code) Sheila SPRIGGS Northshine Dave MD 21237 Baltimore 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt - 2 CL Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Belank Rd, Balt. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HYDOXIC Kespiratory disease or condition resulting in death) hours /Medical Due to (o as a consequence of): Septic Shock Examiner 1 day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) days law requires that the death certificate be executed attending physician and for use as the burial-transit Preumoria Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco.use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should i Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director; After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD RES - 000 2007 n address of person who completed cause of death (Item 23a) (Type, Print) Tithall Blaha Raltimore, MD 600 N. Wolfe St. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

MAY 04

			1 - State Registrar	State of Ma	Cei	rtificate of			Reg. No.200	7 14479	
len:	Physici		1. Decedent's Name (First, Middle, Last) Augustus Rolar	nd Steng	er			2. Date of De Month	MA ^{Pay} 2, 2	3. Time of Death 2027 3:49А м	
	/Medio Examir		4a. Facility Hame (If not institution pive s			4b. City, Town, o	r Location of Death	1		Death altimore	
	Funeral Director		5. Social Security Number 21.7-20-4578 Usual Residence of Decedent 6. Sex 1 ☑	7. Age	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min,	8. Date of Bir (Month, Da		9. Birthplace (State or Foreign Maryland	
laryland show		or	10a. State 10b. County Md. Baltimo:	re	10c. City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☒ No	
Maryland 21215-0036	h with the P 23a or 28a- st be notifi	Funeral Director	10e. Street and Number 22 Acorn Circle	Apt 101		10f. Zip Code	286		10g. Citizen of Wh	nat Country?	
	be filed within 72 hours after death with the Marylar Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent E Armed Forces? 1 ☑Yes 2 ☑ N If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	- 14. Race Black,	- American Indian, White, etc. White	
	within 72 ho ene. than "natur he Medical B	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	(Give life. L	dent's Usual Occup kind of work done DO NOT use retired	oation during most of wor d)	16b. Kind of Business/Industry				
2	filed Hygi other ent, tl		17. Father's Name (First, Middle, Last)	+4	1112	SEC COI	18. Mother's Nan	ne (First, Middle,	Reside Maiden Surname		
/lan	should be filed vand Mental Hygies marked other taumatic event, th	To Be	August C. Stenge	r			Marie	Miller	•		
Mary nd 2 sho	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type. Print) Mrs. Sallie Stenger/ Wife 19b. Mailing Address (Street and Number or Rural I								
Baltimore,	Pages 1 and of He Int: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other plac	ce)	Date	20c. Location - C	ity or Town, State	
<u>=</u>	Pa ant: ury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral → rvice License	- 2	Hilltop 9	Service C		-07	Towson	<u>, Md.</u>	
Ba	permit. Departr Importa any Inji		21. Signature of Thierar Tivice Electrise	1		Ruck T	owson Fu ork Rd.	neral Ho	me, Inc. Md. 2120	1.	
	Physician		23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RESPIRATORY FAILURE disease or condition								
	/Medical Examiner		resulting in death)	CARDIO	consequence of): GENIC SH(DCK					
	\$ #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of).					=	
	xecuter and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		MYOCARDIA consequence of):	AL INFA	RCTION				
68/60,	tificate be executed g physician and as the burial-transit	edical E	d.								
	= 0,10		IF FEMALE:	c. If yes, outcome p	of programov						
P.O. Box	t the c sy the ached	Physician/N	23b. Was decedent pregnant In the past 12 months? 1 Yes 2 No 9 Unknown	1 □Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other <i>(specify)</i>	/		23d. Date Monti		
	quires that n signed build be det		Part II. Other significant conditions cont PNEUMONIA	ributing to death but	t not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to		ute to the cause of death? ☐ Probably 4 ☐ Unknown	
Records,	sician: The law requir certificate has been si irector, page 2 should b	Completed by	RENAL FAILURE					24a. Was autop perfo	sy prie rmed? dea	ere autopsy findings available or to completion of cause of ath? Yes 25 No	
Vital		BeC	25. Was case referred to medical examiner?				26. Place of Dea			Yes 2∰No	
or v	Physic this ce al dire	ျ	1 ☐ Yes 2 No	spital: 1 Nnpatien			4 LI Nursing H		dence 6 DOther		
	ing After	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	Wor	yat k? Yes 2 ∐ No	28d. Describe h	now injury occurred		
DIVISION	를 를 들	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injur building, etc.	y - At home, farm, stre (Specify)	eet, factory, office		28f. Location (S City or Tou	Street and Number vn, State)	or Rural Route Number,	
	To the Hospital of within 24 hours at To the Funeral Completely filled in completely filled in the total completely filled in the total completely filled in the filled in	ledical C	29a. Certifier (Check only one) Certifying Physl	cian: To the best of er: On the basis of and manner stat	examination and/or inv	occurred at the tirvestigation, in my c	me, date and place	, and due to the rred at the time,	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)	
	To the I within 2.	M	29b. Signature and title of certifier			29c. Licens			29d. Date signed (
1	241		1 dece	~	a-	D308			>-2	-07	
1	0		30. Name and address of person who con FRANCIS T. KHOO	M. D.	7601 09	SLER DE	RIVE TO	wson,	MARYLAN	ID 21204	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 4 2007	32. Registrar	's Signature	de					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month /Medical 04 29 07 1900P Bernice J Smith 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Maryland Montgomery 5. Social Security Number 7. Age (In yrs. last birthday, 6 Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2 🔀 F 224-48-5843 Director 70 04/26/1936 Chatham, VA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar more. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits D C Directo Washington, D C 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 422 Butternut St N W #14 20012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2/CXNo If Yes, Give Year or Dates: 1X Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursea Aide Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James L Smith Dorothy V. Whitehead 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John D. Smith (Brother) 2734 West Cabot St Phil. PA 19121 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 7,2<u>007 |</u>Chatham, Virginia Chatham Cemeterv 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Austin Royster Funeral Home ▶ Terry A Austin #846 3821 14th Street N W Washington D C 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic Lymphocytic Leukemia /Medical Due to (or as a consequence of) Examiner <u>Thrombocytopenia</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Rectal Bleeding attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2X No 1XX npatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, n 24 hours after deatn.

he Funeral Director: A
notetely filled in by the ft To the within 2

6

DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier

Kanwalsit Kajr Năgi MD

(Check only



and manner stated.

m

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Rd Silver Spring Md. 20910

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0056063

29d. Date signed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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	D.	For State	Certificate of	Dealli		2. Date of Death	10.	3. Time of Death	
- Physicia		Decedent's Name (First, Middle,Last)	i	Month Da April 28, 200	y Year	1720 hrs			
xamir	er	Shirley A Shoulders						h	
	4	a. Facility Name (if not institution, give street and number)	4	4b. City, Town, or Location of Death			Montgomery		
		Washington Adventist Hospital		Takoma Pa	rk			10111	
E	E	Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Yea		8. Date of Birth(N	MM/DD/YYYY) 9. B	inthiplace (State or	
Funeral Director		1	7 Yrs	Months Days	s Hours Min.	Nov. 24	1949 C	www.shington	
Director		1 1 1 1 1 1	113	<u> </u>		1104. 21	, 10101		
		Jsual Residence of Decedent	Oc. City, Town or Locat	ion		10.00		10d. Inside City Limits	
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aryla 8a-f	퓛	0e. Street and Number		10f. Zip Code		Tog.	Citizen of What oo	onay.	
or 2	Director	3405 13th P1 S E #302		2003	32		LISA		
r death with the Maryland or items 23a or 28a-f shov must be notified at once.		11. Marital Status 12. Was Decedent I	ver in U.S. 13. Wa	as Decedent of His	spanic Origin? (Si	ecify Yes or No-	14. Race - Ame White, etc.	erican Indian, Black,	
eath wi items ust be		1 V Never Married 2 Married Armed Forces?	lt Y	es, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Wille, etc.		
or it	킖	Yes 2	X No	Yes 2 x No	specify:		Specify:	Black	
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	3	or Dates'	alated) 16a Deceder	nt's Usual Occupa	tion (Give kind of		6b. Kind of Busines	s/Industry	
ours natur	eted	15. Decedent's Education (Specify only highest grade com	during n	nost of working life	e. DO NOT use ret	ired)		at the second	
72 h	e e	Elementary/Secondary (0-12) College (1-4 or 5					Private		
036 ithin 72 re than	dmo	11		omestic	18 Mother's Nam	e (First, Middle, Ma			
5-0036 iled within 77 Hygiene. I other than	္ပို	17. Father's Name (First, Middle, Last)						1	
21215 uld be file Mental H marked c event, t	a	Nello Shoulders			Flori	ta Walker	er, City or Town, Sta	ate, Zin Code)	
ID 21215-003 should be filed within and Mental Hygiene. 7.7 is marked other that natic event, the Med	ျှ	19a. Informant's Name/Relationship (Type, Print)							
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Menla Hygieneth ten 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	1	Aretha D Wright (Daughte	er) 4315	<u>3rd St S</u>	E #302	Washingto	n D C 2 20c. Location - City	0032	
ore, MEss 1 and 2 street Health au If item 27 ther traums	ı	20a. Method of Disposition	ZOD. I Idoo of Biops		emetery,	Date	200. Eduation - City	or comi, otats	
Ore es 1 of H if i		1 X Burial 2 Cremation 3 Removal from Sta	Glenwood		05	/05/07	Washingt	on, D C	
Pag Pag ment tant:	ļ	4 Donation 5 Other Specify:	d Tellwood	Name and Addre					
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum		21. Signature of Funeral Service Licenses			/ /			eral Home	
മ ಕೆರ್ಕಕ		Janet Cl	3	821 14th	STREET	N W Wash	t, shock, or heart	C 20011 Approximate Interval	
sician		23a. Part Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do not enter	the mode of dying	g, suomas cararao	o, 100peta.,		Between Onset and Death	
ledical		Immediate Cause (Final disease a. Gastrointestina	l Hemorrhage					Death	
Examiner		or condition resulting in death) Due to (or as a cons						Į i	
		b							
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a cons	equence of):						
	Examiner	cause. Enter Underlying Cause C.							
ost v.	xar	(Disease or injury that initiated events resulting in death) Last Due to (or as a cons	equence of):						
uted uted nd ransi		d							
exec an an	<u>s</u>	UNPENDED AMENDED							
8760, Edificate be executed in physician and as the burial - transit	n/Medical	IF FEMALE: 23c. If yes, outco	me of pregnancy				23d. Date of del		
976 iffcal ng ph	[23b. Was decedent pregnant in the 1 Live birth	4	Fetal death	3 Ectopic preg	nancy	Month	Day Year	
cert cert endir use a	ci a		t time of death 5	Other (Specify)			1		
Box 68 le death certi the attendir	Physicia	1 Yes 2 No 9 Unknown 9 Unknown				Loo- Did to	nance use contribut	e to the cause of death?	
the by the	돈	Part II. Other significant conditions contributing to dea	th but not resulting in th	e underlying caus	e given in Part I.		23e. Did tobacco use contribute to the cause of death?		
Division of Vital Records, P.O. ral or Attending Physician: The law requires that it is after death. In Director: After this certificate has been signed by the the control of the contro	≥					1 Yes 2 No 3 Probably 4 V Unknown			
S, luires	ompleted					24a. Was a		re autopsy findings available r to completion of cause of	
ord v rec s bee	je					autop:	med? dea	th?	
e lay	티토					1 ✔ Yes	2 No 1	Yes 2 No	
Fire Tifica	၂ ပ	25. Was case referred to medical		26.PI	ace of Death (Che	ck only one)			
ician ician s cert	å	examiner? Hospital: 1 Inpat	ient 2 🗸 ER/Outpati	ent 3 DOA	Other Nu	rsing Home 5	Residence 6	Other:	
Phys.	<u> </u>	1 Yes 2 No			Injury at Work?	28d. Describe	now injury occurred		
Afte		27. Manner of Death 1 Natural 5 Pending 28a. Date of Ir (Month, Day	(Year)	1	Yes 2 No				
ior tend eath.	₩	Natural 5 Pending 2 Accident Investigation			as building ats	28f Location (5	Street and Number	or Rural Route Number, City	
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Division Hospital or Attend 24 hours after death. Funeral Director:	Certification:	4 Homicide determined (Specify)				1			
lospi t hou		29a. Certifying Physician: To the best of	my knowledge, death or	ccurred at the time	e, date and place,	and due to the caus	e(s) and manner as	s stated.	
Division of Vital Records, P.O. Box 68760, To the Hospital or Alending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Birectors.	Medical	29a. Certifying Physician: To the best of (Check only one) 2 Medical Examiner: On the basis of example of manner state	camination and/or invest	tigation, in my opi	nion, death occurr	ed at the time, date	and place, and date	10 110 0000 (-)	
To the within To the	1 P	and manner state	0		ense number		29d. Date signed	(Month, Day, Year)	
lacksquare	2			0	.C.M.E.		April 29, 200	7	
		(aboberul)							
-		30. Name and address of person who completed cause of		0,	- Minn out - NATO (1201			
The state of the s		Laron Locke MD. Assistant Medical E		enn Street, Ba	altimore, MD 2	1201			
	Stat	31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	1 10					
Rec	istra	E.	H. A	marks)					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland / Dep	partment of Health an ertificate of Death		LUU1 19902
			Decedent's Name (First, Middle, I			Reg. I	No. 3. Time of Death
	Physici /Medi		Joseph	Str	AZZINE	Month 3	Day Year 1:15 AM
I.	Examir		4a. Facility Name (ff not institution, g		4b. City, Town, or Location of D		4c. County of Death
				Aris Hospice			BAltimore
п	Funeral Director		5. Social Security Number 6 212-07- 29:8	. Sex 7. Age (In yrs. last birthda 1 M 2 F G 2 Yrs.		Hrs. 8. Date of Birth Min. (Month, Day, Yea	
			Usual Residence of Decedent			Sept Z	1913 MARYLAND
	death with the Maryland ms 23a or 28a-f show		10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	rith the Maryla or 28a-f sho	cto		imore Time	ONIUM		1 ☐ Yes 2 ☑ No
	or 2	Director	10e. Street and Number	. /	10f. Zip Code		Citizen of What Country?
	death w	Funeral	2300 Dula	12. Was Decedent Ever in U.S. 13	21093		U.S.A.
10	b # 9	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, President 	(Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-0036	(0 - 5	by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: White
5-0	"natural"	Completed	15. Decedent's (Specify only highest of		cedent's Usual Occupation ve kind of work done during most of	16b.	Kind of Business/Industry
2121		npje.	Elementary/Secondary (0-12)	College (1-4or 5+)	. DO NOT use retired)	172	ethlehen Steel
	e filed v Il Hygie other ti vent, Its		17. Father's Name (First, Middle, La.	ce)	Steelworker		1
and	d be f antal h ad of	Be	UNK	11)	18. Mothers	Name (First, Middle, Maide	in Sumame)
Maryland	s 1 and 2 should be filed withing Hoeith and Mental Hygiene. Item 27 is marked other than other traumatic event, Item	유	19a. Informant's Name/Relationship	(Type, Print) 19b Ma	iling Address (Street and Number of	CNK Bural Boute Number Cib	or Town, State, Zip Code) Z 1084
∑.	nd 2) J	2	-Azzire-SON 3			Dr. Jamestville MD
ē,	of Hee	1	20a. Method of Disposition	20b. Place of Dis	position (Name of rematory or other place)		Location - City or Town, State
Baltimore	Page ent c nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 75 🖾 Other (Spec			W 4 2000 Br	Home or Marchan
a E	permit. Page Department Important:	T	21. Signature of Puneral Service Lic	eńsee	22 Name and Address of Facility	7 3 300 10	Funcas Home
8	Dep Imp		1/2/3		263 5. CONKI	ing ST BAI	to MD 21224
	Physician /Medical Examiner		23a. Pert Enter the disease, coshock, or heart-failur. st on lmmediate Cause (Final disease or condition resulting in death)	mplications that caused the death. Do not ely one cause on each line. a	nter the mode of dying, such as care	diac or respiratory arrest,	Approximate Interval Between Onset and theath
	xecuted and I-transit	Examiner	Saquernially fiet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c. Due to (or as a consequence of):			
8760,	ate be ex hysicien the buria			d			
9	ificate g phys as the	edic		d.			
P.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	res that igned b	by P	Part II. Other significant conditions	contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
of Vital Records,	quire on sig uld b	pa pa	Prostrate	Cancer		1 ☐ Yes	2ÈNo 3 Probably 4 □Unknown
ပ္တ	aw requir s been si 2 should	Completed				24a. Was an	24b. Were autopsy findings available
æ	The law cate has page 2 s	E O				autopsy performed?	prior to completion of cause of death?
ita	slcian: T cartificat rector, pa		25. Was case referred to medical examiner?		26. Place of D	Death (Check only one)	lo 1 Yes 2 Vo
<u>></u>	hysica his ca I dire	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	0.11	g Home 5 Residence	6 ☐Other (Specify)
D C	inding Physician: th. After this cartification funeral director, in		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury at	28d. Describe how inj	
sio	Attendil death. ctor: A y the fu	cat	2 ☐ Accident investigate 3 ☐ Suicide 6 ☐ Could not	be	M 1 ☐ Yes 2 ☐ No		
Division	or after	Certification:	4 Homicide determine	d 289. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town, Sta	
	he Hospital in 24 hours in he Funereit pletely filled	edical	29a. Certifier 1 ☑ Certifying P (Check only one) 2 ☐ Medical Exs	hysician: To the best of my knowledge, dea miner: On the basis of examination and/or in and manner stated.	ath occurred at the time, date and pla nvestigation, in my opinion, death oc	ace, and due to the cause(s courred at the time, date an	s) and manner as stated. Indicate place, and due to the cause(s)
	To the within 2	Σ	29b. Signature and title of certifier	In Charlet MAN	29c. License number	A P	ate signed (Month, Qay, Year)
,			J nestin	e volum, void	0527	40 11	lay 319 2007
1	l			completed cause of death (Item 23a) (Type			
Ų.	-64		ERNESTINE WRIG. 31. Date filed (Month, Day, Year)	HT', M.D. 2300 DU. 32. Registrar's Signature	LANEY VALLEY ROA	D TIMONIUM	MD 21093
	Sta Registra	.6	MAY 0 4	7007 See Ann A	Coreles		

MAY 3, 2007

STRAZZIRE, JOSEPH

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: within 2. To the I

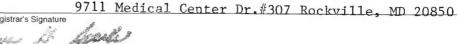
> G State Registrar

Bernard J.

31. Date filed (Month, Day, Year)

Rogus 32, Registrar's Signature MAY 0 4 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



27786

29d. Date signed (Month, Day, Year)

5-2-2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 26 per verb 286/5-4-0/vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Year ee 07:27F M 01, 2007 /Medical MAY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Saint Joseph Medical Center Towson Baltimore if Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1**∭** M 2□ F 31-32 Director 6 Keeclv !le Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at angle. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo nado 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be norne ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mac 1 pays Inoche DIDLON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State reval Chapel Bolfir 5/2/07 22. Name and Ad ress of Facility 3 Newpor 4 □ Donation 5 ☐ Other (Specify) Orest Hill 21. Signatur of Funeral Service License Dr., Forest Hill, MD Evans Luneral 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY FAILURE /Medical Due to (or as a consequence of): **Examiner** FULMONARY FIBROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,%CORONARY ARTERY DISEASE
Due to (or as a consequence of): nding physician and Physician/Medical NON-HODGKIN'S DISEASE LYMPHOMA IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown signed by d be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by MYOCARDIAL INFARCTION Completed 1 Yes 2 No 3 Probably 4 Unknown ISCHEMIA CARDIOMYOPATHY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 No page certificate 1∐ Yes 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 🔀 No After this 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural Year) 5 Pending investigation al Director: / 1 TYes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) MO 5-1-07 icun D31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature OSLER DRIVE TOWSON, MARYLAND 21204 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month August G. Tegeler 11:30 P M May 1, 2007 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 M 2 F 84 Yrs 216-12-9657 2/2/1923 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore 1 ☐ Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3117 Parktowne Rd. 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Nes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 █No Specify: white 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Bloomingthal Elementary/Secondary (0-12) College (1-4or 5+) Electric electrician 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Tegeler Frances Scheafer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joseph Tegeler/ son 4 West Irving Dr. Baldwin, MD 21013 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Cemeteryd Cemeteryd Parkville, MD 4 ☐ Donation 🤰 ☐ Other (Specify) 21. Signa Evans Funeral Chapel 8800 Harfo & Cremation Services Parkville, of Funeral Service License 8800 Harford Rd. 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Heart Failure disease or conditior resulting in death) Weeks Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) 23d. Date of delivery Month Day Year use contribute to the cause of death? No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 2 No

Physician /Medical Examiner

Physician

YMedical

Examiner

Director

Funeral

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Completed

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Physician/Medical

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Completed

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Certification:

Medical

Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

1 and 2 should be filed within 7 Health and Mental Hygiene.

Injury or other traumatic event,

permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any injury or other trau

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

within 24 hours after death

To the Funeral Director:
completely filled in by the

	_d				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of delivery Month Day Year				
Part II. Other significant conditions of	contributing to death but not re-	sulting in the underlyin	g cause given in Part I.	23e. Did tobac	cco use contribute to the cause of deatl
Atrial Fibrillatio	n			1 ☐ Yes	2 XNo 3 Probably 4 Unkr
Renal Failure Staph Infection				24a. Was an autopsy performe	24b. Were autopsy findings avair prior to completion of cause death? No 1 Yes 2 No
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)	
1 Yes 2 No	Hospital: 12 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence	e 6 □Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how	injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Special	and Number or Rural Route Number, late)			
29a. Certifier 1 X Certifying Ph (Check only one) 2 ☐ Medical Exar	nysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death occurr ation and/or investigat	red at the time, date and plaction, in my opinion, death occ	te, and due to the caus curred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
29b. Signature and title of certifier			29c. License number	29d.	Date signed (Month, Day, Year)

140,

State Registrar

DHMH 17 Rev 1/2001

Carte 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chatham, Marie 6701 North Charles St, Towson MD 21204

31. Date filed (Month, Day, Year)

Thank



MID

D20907

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fb / 867 5-4-07 vt State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death RAL HOSPITA HOWARD COUNTY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 XM 2 ☐ F 214-64-2083 51 Yrs. 04/13/1956 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No HOWARD ELLICOTT CITY 10e. Street and Number 10g. Citizen of What Country? 3408 FOLLY QUARTER ROAD 21042 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry LANCASTER FOODS Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER 12TH CORPORATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ARTHUR W. THOMAS, SR. GERTRUDE MILES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3408 FOLLY QUARTER RD., Eligible City, Md. 19a. Informant's Name/Relationship (Type, Print) ELAINE R. THOMAS / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD NATL MEM. PK 5/5/07 LAUREL, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD the disease, or complications that caused the death eart failure. List only one cause on each line Do not enter the mode of dying, such as cardiac or resiliratory arrest Approximate Interval Between Onset and Death Immediate use (Final disease re-ondition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3X Probably 4 □Unknown 1 ☐ Yes 2 ☐ No. 24a. Was an autopsy performed? 1 ☐ Yes 2 € No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 12 ☐ Accident investigation 3 Suicide 6 Could not be determined

Examiner Hospital or Attanding Physician: The law requires that the deeth certificate be executed physicien and s the burial-transit Box 68760, ettending p

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

rthan "natural", or itsms 23e or the Medical Examinar must be r

other

= 5 Department of Important: If any injury or once.

Physician /Medical Director

Completed by Funeral

Be

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Physician/Medical Examiner

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Completed

Be

Certification:

Medicai

the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

P.0. Division of Vital Records, within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, To the

State Registrar

DHMH 17 Rev 1/2001

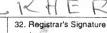
31. Date filed (Month, Day, Year)

MAY 04

RINKIL

4 🗌 Homicide

29a. Certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ORIGINAL

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - For State Amend #26, per verbal from Dr., 6867, 5/4/0/II

Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Apri 950 AM 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number 4c. County of Death **Examiner** J Memoria 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 🔀 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ange. 10a. State 10c. City, Town or Location 10b. County Inside City Limits MD 1 tes 2 No Funeral Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 500 Greendale 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use regred) Elementary/Secondary (0-12) College (1-4or 5+) Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City (Daughter) 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as I consequence of): **Physician** disease or condition resulting in death) /Medical Examiner SE Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Pneumona burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à TAPH MRSA 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed PSORIATIC 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director: A filled in by the fu 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 5/03/2007 29c. License number 29b. Signature and title of certifier D16189 ren N. Callar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 W. Charles St 4615 TOWSON MD 21209 N. KARKAR MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Via May 10:15 A M Oi 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A Kentucky Avenue 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, (Month, Day, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F 215.38-221 Yrs. 11/18/1940 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits A Show.

2 And Mental Hygiene.

1 Is marked other then "natural", or items 23e or new.

1 Is marked other then "natural", or items 23e or new. MD 1 XYes 2 □ No Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3345 USA Kentuck Menue Funerai filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 2 No Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

OHICE ASSISTAN 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical 12th grade 2 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Campor Gladys Brooks ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 Is
eny Injury or other treu 3345 Kentucky Avenue Tilghman Husband Balto. MD Anthony 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 05/08/07 Owing Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral Sucs 4905 York Road Baltimore, MD 21212 augher 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart jailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Gastrointestinal Stromal Tumor 6 months /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) ettending physicien a for use as the burial-Division of Vital Records, P.O. Box 68760 by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Day 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? has been signed to a should to Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? s certificete ha autopsy performed 1 ☐ Yes 2 No 1 Yes 2 XNo director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Japiter - A hours after dec. 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a
To the Funsrs! E
completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) ş 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٩ 2 D4027 May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Blud Baltimore MD 2123 Thomas Wilson M 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 0 4 2007 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Dav Amy L. Tapparo 4:45 PM 2007 30. April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 11821 Glen Mill Road Montgomery Potomac 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Hours Months 1 M 2 ST F 43 577-70-2468 August 18, 1963 Washington D.C. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County show ms 23a or 28a-f shov must be notified at Director Maryland Montgomery 1 TYes 2 No Potomac 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 11821 Glen Mill Road 20854 United States Funeral death d other than "natural", or Items event, the Medical Examiner me 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Flight Attendant Airlines 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gerald S. Johnston Dorothy Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trauonce. David Tapparo/Husband 11821 Glen Mill Road, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)
Potomac United Methodist 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 Removal from State May 4, 2007 Potomac, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence of): Examiner Pulmonary Metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed Metastatic Adenocarcinoma of the Breast and the burial-trar Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as asn 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No Division or Vital Records, P.O. the 9 Unknown 9 Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2 🖾 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Cohertistane MD21025 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert D. Warren, M.D. 3800 Reservior Road, N.W., Washington D.C. 20007-2113 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAY 0 4 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2007 Alan S. Town 6:15 PM May 1. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14016 Shippers Lane Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1**X** M 2□ F Hours Feb. 16, 1954 378**-**64-4564 53 Director Michigan Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits la or 28a-f show t be notified at 1 XYes 2 No Directo Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20853 14016 Shippers Lane United States "natural", or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event the Landing Once. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Law Office Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sherman Town Dorothy Marie Warwick 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeraldine P. Town/Wife 14016 Shippers Lane, Rockville, Maryland 20853 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20c. Location - City or Town, State 20a. Method of Disposition May 4, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Bethesda, Maryland Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service Licenses M00198 300 West Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metastatic Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) been signed by the should be detached 1 TYes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal Cell Cancer 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ဥ 1 ☐ Inpatient funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🔀 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours a

To the Funeral I
completely filled

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

04

Cynthia M. Williams, D.O. 6001 Muncaster Mill Road, Rockville, Maryland 20855 32. Registrar's Signature

a m Milliams

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

HW58032

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items / 8 per fh e867 5-8-07 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Mark Barrett Thompson 30, April 2007 2355 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 1953 Birthplace (State or Foreign Country) **Funeral** Hours Months Days 216-58-5414 124M 2□F -53 Director December 4, 1954 New Mexico Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linury or other traumatic event, the Medical Examination. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery 1 □ Yes 2 K No Director Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14608 Sturtevant Road 20905 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Maryland Department Elementary/Secondary (0-12) College (1-4or 5+) Emission Control Inspector of Motor Vehicle 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Caspar Morris Thompson Josephine Noonan ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tom Thompson / Brother 5901 Beech Avenue, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Montgomery Crematorium May 3, 2007 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Bethesda-Chevy Chase Inc. Bethesda, Maryland 20814 21. Signature of Funeral Service Linense Pumphrey Funeral Home 7557 Wisconsin Avenue M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Min /Medical Examiner cong Arlang Duran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1. Probably 4 Unknown Completed Chance funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy 2 No 1∐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 | Yes 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Medical Der 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 07

State

Registrar

18101

32. Registrar's Signature

MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

31. Date filed (Month, Day, Year)

MAY

0 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 April 24 Physician 11:30 P M Rita Tschabrunn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 □ M 2 🔀 F 1931 New York 115-24-4096 75 Director Sept. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 U.S.A. 6334 Cedar Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 3K Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry illed within 72 h I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, <u>ti</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Greytak Grace Stewart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, MD 21045 Joann Allen (Daughter) 6596 Robin Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4/30/2007 Metro Crematory Catonsville, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. M01050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5555 Twin Knolls Road Columbia, MD 21045 Immediate Cause (Final Physician disease or condition resulting in death) Lung Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Chause Unions that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical as the 1 esn 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy lor in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð pe 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was a... autopsy performed? has certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 3 ☐ Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 ☐ Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

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Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Raj Chawla, M.D.

31. Date filed (Month, Day, Year)

D0053709

14300 Gallant Fox Lane Suite 210 Bowie, MD 20715

4/25/2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				1 - For State Registrar	State o	f Marylan		artment of H		Mental Hy	giene Reg. No. 0 0 7	14493
		Bhusia	ian	Decedent's Name (First, Middle, La	,					2. Date of De	ath	3. Time of Death
<u> </u>		Physic /Medi	cal	JARVIS		MAS				Month MAY	1,2007 ear	10:20PM
	E.	Exami	ner	4a. Facility Name (If not institution, giv				•	or Location of Dea	ath	4c. County of Deat	
		Funeral		JOSEPH RICHEY 5. Social Security Number 6. S	Sex	7. Age (In yrs.	last birthday)	BALTIN If Under 1 Year			N/A th 9. Birt	hplace (State or Foreign
		Director			□M 2□F X	81	Yrs.	Months Days	Hours Mir	 (Month, Da 	3,1925 N.	untry)
		and aw		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
		Mary I-f ehd	to	MD. N/A			F	ALTIMOR	7 F			1 ☐ Yes 2 ☐ No
5		urs after deeth with the Marylar et, or iteme 23a or 28a-f ehow Exandrar cast be routified at	Director	10e. Street and Number				10f. Zip Code	(L)		10g. Citizen of What Co	Λ
0	3102 MARECO AVE. 21213									usa		
V	3102 MARECO AVE. 21213 11. Marital Status 1 Never Married 2 Married							fispanic Origin? (an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	14. Race - Ame Black, White		
0	936	or, or	þ	3 Widowed 4 Divorced	If Yes, Giv Year or Da	/8		☐ Yes 2√2 No	Specify:		Specify: BL	ACK
-	5-003	filed within 72 hours after deeth with the Maryland Hygiene ither then "nature!", or Iteme 23a or 28a-f ehow ont, the Medical Examiner trust be rectified at	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced	lent's Usual Occup	pation during most of we	orkina	16b. Kind of Business/	Industry
	2121	d within giene. r then	gm	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. L	DO NOT use retire	d)	,g		
1		e filed Il Hygie other	O O	17. Father's Name (First, Middle, Last)			CRAN	E OPERA		ame (First, Middle	BETHLEHEM Maiden Sumame)	STEEL CO
1	aryland	ਰ ਲੋੜ ਹੈ ●	To B	TURNER THO	MAS				MATT	IE FLEE	TWOOD	
7	lar	2 2 0 0	ľ	19a. Informant's Name/Relationship (19b. Mailin	g Address (Street	and Number or F	lural Route Numb	er, City or Town, State, 2	(ip Code)
- 1	e, M	f Heelth item 27 other tra	L	KEITH LAMELLE ' 20a. Method of Disposition	THOMAS	(son)	3102	MARECO	AVE.		RE,MD. 21	
D	Baltimore	S = = 0		1 ☑ Burial 2 ☐ Cremation 3√		State	emetery, cren	natory or other place	1	Date	20c. Location - City or MURFREES:	BORO, N.C.
5	Ē	permit. Page Department of Important: If any injury or once.		4 Donation 5 Other (Specification 21, Signature of Funeral Service Licer		CA		PARK C		Y 8, 20	07	•
à	ä	Deprison of the control of the contr		Demadine	· Del	rug	C	ALVIN B 412 E.	. SCRU	GGS FUN	ERAL HOME	01010
0				23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that co	aused the death	. Do not ente	er the mode of dyin	ng, such as cardia	ic or respiratory a	ALTO, MD.	21213 Approximate Interval Between
4		Physician		Immediate Cause (Final disease or condition resulting in death)	a Chro	nic obs	tructi	re pulm	onary d	isease		Onset and Death
	1	/Medical Examiner		resulting in dea(n)	Due to (or as a consequ	uence of):					
			er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	uence of):					
1	12	sicien and burial-transit	Examiner	that initiated events	C.							
,	Ö	cate be executed physicien and the burial-transit	Ex	resulting in death) Last	Due to (or as a consequ	uence of):					
	,8760,	phy the	dlcal	•	d							
1	9 xo	The law requires that the death certific te hes been signed by the ettending p tage 2 should be deteched for use as	by Physician/Me	IF FEMALE:	23c. If yes, out	come of pregna	ncv				004 Data (44)	
Z	Ä.	death e etter d for u	Iclar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live bi 4 ☐ Pregna	irth 2 □Fetal ant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
2	P.0	that the de ed by the deteched	hys	9 Unknown	9□ Unkno							
E	S,	ires the signed I be de	by	Part II. Other significant conditions of	ontributing to de	ath but not resu	ilting in the un	derlying cause give	en in Part I.		obacco use contribute to	/
1	Ö	w requir been s should	eted	Viabetes						-	res 2□No 3 Pro	
4	Rec	The law sete hes page 2 s	Completed							24a. Was autop perfo	an 24b. Were aut prior to c rmed? death?	topsy findings available ompletion of cause of
2015	Vital Record		Be Co	25. Was case referred to medical				_	26 Place of De	1 ☐ Yes ath Check only o	2 No 1 Yes	2 □ No
14	of Vi	Physician: this certificatal director, I	To B	examiner? 1 Yes 2 No	Hospital: 1 🗆 Ir	npatient 2 1	ER/Outpatient	3□ DOA Oth			lence 6 Other (Spec	IN HASDICO
17		fing Ph	on:	27. Manner of Death 1 ØNatural 5 ☐ Pending	28a. Date o (Monti	of Injury h, Day Year)	28b. Time of Injury	28c. Injun Work		-	now injury occurred	" ijo-picc
, 1	Division	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	-	of Injury At ho			Yes 2 ☐ No	206 Lasstine (6	· · · · · · · · · · · · · · · · · · ·	
	Θ	of or A	Certification;	4 Homicide determined	buildin	ng, etc. (Specify)	et, factory, office		City or Tow	Street and Number or Ru m, State)	rai Houle Number,
		To the Hospital or Attending Physician: Within 24 hours eller death. To the Funeral Director Affer this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Example 1	ysician: To the hiner: On the ba and mann	isis of examinati	wledge, death ion and/or inv	occurred at the timestigation, in my of	ne, date and place pinion, death occi	e, and due to the ourred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
_		Fo the Mithin 2 Fo the comple	Me	29b. Signature and title of certifier	with the state of	o. stated.		29c. License			29d. Date signed (Month	
		0		> Ston wa				D2	4170		May 3 20	07
		(A)		30. Name and address of person who o	completed cause	of death (Item	23a) (Type, F	rint)	0 11.	1.4.5	May 3, 20 > 21201	
		<u>پ</u>		E SOMD Kiche	y Hospic	e 838	NEW	taw st	Baltim	ere Mi	21201	

Registrar

MAY 0 4 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Formend #7 Per FH State of Maryland I Pepartment of Health and Mental Hygiene Registrar 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Dav **Physician** Year : 08 PM TURNER FAUNIE mai 2 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore The Johns HOOKINS Hospital N/A If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖳 F 216 38 7313 65 Director MAR. 29,1942 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2 □ No Director N/A MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5906 SCHERING ROAD 21206 USA Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. ☐ Yes 2√ No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: BLACK 3 ₩idowed 4 Divorced Year or Dates: 'natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. TOWSON Elementary/Secondary (0-12) College (1-4or 5+) FOOD SERVICES UNIVERSITY 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be 1 Mental ROYSTER GOODS VERGIE FAULKNER Pages 1 and 2 should nent of Heaith and Men 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 5906 SCHERING ROAD SHARON D. GOODS (daughter) BALTO, MD. 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MAY MEM. 10,2007 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH BALTIMORE, MD. 21. Signate of Funeral Service Licenses 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PRESTON ST. BALTO, MD. 213 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or a) a consequence of): **Physician** /Medical Examiner heart Sequentially list conditions, it and a sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-transit requires that the death certificate be executed lm onar P.O. Box 68760, Physician/Medical SBS IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month 4□Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe Yes 2 1 ☐ Yes 2 ☐ No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 Tes ٩ 2 ER/Outpatient 3 DOA Date of Injury 28b. Time of 27. Manner of eath Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) Natural Injury To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 TYes 2 TNo 2 Accident 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 MEDICAL DUCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hopkins Hospital 600 North worte Street Baltimore Dewin The

DHMH 17 Rev 1/2001

State

Registrar

31. Date-filed (Month, Day, Year)

MAY 0 4

2007

32 Registrar's Signature

Physicia: /Medica Examine **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 To Be Completed by Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760% Certification. To Be Completed by Dhysician/Medical Ev

6:40 р.ш.

APRIL 30, 2007

JOHN WALDNER SR.

State of Mar State Registrar	ryland / Depa	artment of H	ealth ar		ntal Hyg	iene	17 14.4	. 05
negistrar Decedent's Name (First, Middle, Last)		timouto or .			Date of Deat		3. Time of	Death
John R. Waldner, Sr				A	pril .	30°,200°	6:40	P _M
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of	Death		4c. County of	f Death	
Stella Maris			nium			Balt	timore	
1 □ X M 2 □ F	(In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	Date of Birth (Month, Day,	rear)	Birthplace (State of Country)	r Foreign
Usual Residence of Decedent	76 Yrs.			F	eb.11	,1931 I	Maryland	
	10c. City, Town or Lo	ocation					10d. Inside Ci	ty Limits
MD Baltimore		Parkvil	lle				1 □Yes	2 X) No
10e. Street and Number		10f. Zip Code			10	Og. Citizen of Wh	nat Country?	
8813 Alnwick Road		212	234			Ţ	JSA	
11. Marital Status 12. Was Decedent Ev Armed Forces?		Was Decedent of H If Yes, specify Cuba	spanic Origi n, Mexican,	n? (Specif Puerto Ric	y Yes or No-		- American Indian, White, etc.	
1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No		1 ☐ Yes 2 🗓 No	Specify:		,	Specify:	White	
3 ☑ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education	16a Daca	dent's Usual Occup	ation			16b. Kind of Bus	in and (Individual	
(Specify only highest grade completed)	(Give	kind of work done of DO NOT use retired	furing most o	of working	1		ore City	
Elementary/Secondary (0-12) College (1-4or 5+)	efighte			1 -		epartment	t
17. Father's Name (First, Middle, Last)	•	-	18. Mother's	s Name (F		Maiden Surname		
Phillip Waldner			Rose	Mar	у Нарр	pel		
19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	and Number	or Rural F	Route Number,	City or Town, S	tate, Zip Code)	
John R. Waldner, Jr-son	53 D€	ep Channe	el Dri	ve-Be	erlin,M	aryland	21811	
20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, cre Dulaney Memorial	osition (Name of matory or other place ALLEY	e) Ma	ay 4,			ity or Town, State n,Maryland	
21. Signature of Funeral Service Licensee		Gardens 2. Name and Addres			8800	Harford	Road	
andrio h ME tark	. FN	ANS FUNER D CREMAT	AL CH	APEL	Dl-		aryland 21	234
Due to (or as a	LIVER DISE consequence of):		g, such as ca	ardiac or r	espiratory arre	est,	Approximatinterval Bet Onset and I	ween
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pind the past 12 months?	Due to (or as a consequence of): d. FEMALE: Bb. Was decedent pregnant in the past 12 months? 1 Yes 2 No No No No No No No							
Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause give	en in Part I.		23e. Did tob	acco use contrib	oute to the cause of d	eath?
				_	1 □ Ye	s 2□No 3	B□ Probably 4 欠 l	Jnknown
				-	24a. Was ar autops perforn	y pri ned? de	ere autopsy findings ior to completion of c ath?	available ause of
1								
examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient	t 2 ER/Outpatie	nt 3 DOA Othe					(Specify) HOSP	——— ТСБ
27. Manner of Death 1 Natural 5 Pending (Month, Day) 2 Accident investigation	28b. Time o	f 28c. Injur World	/ at	280		w injury occurred		ICE
o□ cuitte 6□ Could not be	y - At home, farm, sti (Specify)	reet, factory, office		28f	Location (Sti City or Town	reet and Number , State)	r or Rural Route Num	ber,
29a. Certifier (Check only one) 1 Certifying Physician: To the best of and manner state and manner state	examination and/or in	th occurred at the tin	ne, date and pinion, death	place, and occurred	d due to the ca at the time, da	ause(s) and man ate and place, ar	ner as stated. nd due to the cause(s	;)
29b. Signature and title of pertifier		29c. License	number		29	d. Date signed	(Month, Day, Year)	
1		1)(137	21		5/1	107	
30. Name and address of person who completed cause of dea	ath (Item 23a) (Type.	Print)	()/					
	LANEY VAL		TIMONT	UM.	MD 2109	93		
31. Date filed (Month, Day, Year) 32 Registrar	's Signature					_		
MAY 0 4 2007	J. Ac	all)						

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State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 04 Physician LOYD WILITAMS ^{Year} 2007 19:49 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09-15-1935 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 X M 2 □ F Hours 228-40-7054 Yrs Virginia Director Usual Residence of Decedent 10b. County 10c. City, Town or Location Washington 10d. Inside City Limits 28a-f show at n/a notified Director 1XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 4429 6th Place NE 20017 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: 3 Widowed 4 Divorced 'natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Sanitation Worker 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ned Kent Williams Flossie Department of Health and Menta Important: If item 27 is marked on any Injury or other traumatic ev ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Williams Wife 4429 6th Place NE Washington, DC 20017 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resurrection Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 05/03/2007 Clinton, MD 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bianchi 814 Upshur St NW Wash, DC 20011 23a. Part1. Enter the disease, or complications in Caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARLIOMYOPATHY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-tra Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, \$ Chronic Obstructive Lung Disease 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has bage 2 s autopsy 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2X No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral (27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 XNatural 5 ☐ Pending investigation death. ours after death.

Peral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō 29a. Certifier Medical

To the Hospital or within 24 hours aft To the Funeral D completely filled in

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4/26/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dpinder Singh, MD 14300 Gallant Fox Lane, Bowie, MD 31. Date filed (Month, Day, Year) 3. Registrar's Signature

State Registrar

2

MAY 0 4 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Williams Day aloria Month **Physician** 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner time City HOLD 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 220 -36-773 Usual Residence of Decedent 1 □ M 2 1 F Yrs. Waruland Director filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 □ No rede Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 2176 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Bla ğ 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) d other than "nature event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be filed i Department of Health and Mental Hygis Important: If Item 27 Is marked other any Injury or other traumatic event, <u>if</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Husboard) Sr. 7006 Dpul

20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location 20a. Method of Disposition 3 ☐Removal from State 1 ■Burial 2 □ Cremation 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
JOSEPH L. TUS
2222 W. North 21. Signature of Funeral Service Licensee Home salto 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart fail
Immediate Cause (Final
disease or condition
resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): Respiratoru distress a weeks Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner yptogenic curhosis ears The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy for use 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death detached 9□ Unknown 9 Unknown s been signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 TYes 2 No 3 Probably 4 Unknown Completed certificate has been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 No 1 Yes 2 No 1 Tyes Physician: 26. Place of Death (Check only one) director, 25. Was case referred to medical Be examiner? Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To this 28b. Time of Injury Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred completely filled in by the funeral After 5 ☐ Pending investigation or Attending 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier -Medical Poctor Res-000 May 01 2007 30. Name and address of person who completed cause of death (item 23a) (Type, Print) The Johns Hopkins Hospital, 600 North Wolfe, Buttimore, Maryland 21287 Hansic Mathelier,

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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2007

32. Risistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WILSON Month Day 25 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death timore Year If Under 24 Hrs. 8. Date of Birth
Page Hours Min. (Month, Day 9. Birthplace (State or Foreign **Funeral** Days Months Director Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Completed by Funeral Director ltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2**%**No Maryland 21215-0036 1 ☐ Yes 2 X No Specify Blac 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be (18. Mother's Name (First, Middle, Maiden Surname) Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 22. Name and Address of Earlity
JOSEPH TRUSS FOR 21. Signature of Funeral Service License Batto. Ma. Enter the dillesse, or complications that collect he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Pa 11 Immedia e Cause (Final disease or condition resulting in death) PATHY ENCEPMALO Physician /Medical Due to (or as a consequence of): **Examiner** DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 20 No 2☐ER/Outpatient 3☐ DOA P 1 Inpatient After this 27. Mann of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Watural 5 Pending investigation 2 Accident 1 ☐ Yes 2 □ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide **Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, nin 24 hours after death the Funeral Director:

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAY 0 4

and address of person who completed cause of death (Item 23a) (Type, Print)

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29c. License number

Koven

29d. Date signed (Month, Day, Year)

Block - Baltimore

Examiner burial-trar Box 68760. physician pe the as t attending use for signed by the a P.0. Division or Vital Records, Deen has page certificate funeral director, After this or Attending death. within 24 hours after death To the Funeral Director:

Funeral

Director

28a-f show

ral", or items 23a or 28a-f shov Examiner must be notified at

7 is marked other than "natural", traumatic event, the Medical Exa

death with

filed within 72 hours after or Hygiene. Hygiene.

d 2 should be filed within 7 th and Mental Hygiene. **7 is marked other than "r**

s 1 and 2 s of Health ar Item 27 is

it. Pages 1 artment of F ortant: If Ite

permit. Page Department of Important: If any injury or

Physician

/Medical

Baltimore, Maryland 21215-0036

Certification: þ filled in

6 Could not be determined 3 ☐ Suicide 4 Homicide

29b. Signature and title of certifier

29a, Certifie

(Check only one)

elon, M.D.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

DØØ17695

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HELOU 7601 OSLER DRIVE TOWSON. MARYLAND 21204 ABDALLAH M. D. J.

31. Date filed (Month, Day, Year) State Registrar

Medical

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Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** GLADYS Month Day WAGNER /Medical 2007 10:20 A May 1. 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Ridgeway Manor Nursing Home <u>Catonsville</u> Baltimore 8. Date of Birth (Month, Day, Year)
Feb. 12, 1917 Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1□M 2QF Months Hours Min. 90 577-18-4957 Director Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d, Inside City Limits items 23a or 28a-f showner must be notified at Director 1 ☐ Yes 2 🕅 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 314 Tennessee Avenue 21122 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🙀 No Specify. 3 ☑ Widowed 4 ☐ Divorced Specify: White er than "nature, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Communications 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Thomas W. Harris Mary Margaret Compton ၉ of Health and M Item 27 is mar other traumat 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Wagner Son 314 Tennessee Avenue; Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If Ite any Injury or ot 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 5/4/2007 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service License 1630 Edmondson Avenue; Catonsville. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed as the burial-tran and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Day Year 5 ☐ Other (specify) ed by the a detached f 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Uknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autonsy performed' 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 ☐ Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No I or Attend after death 2 Accident completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D

Division or Vital Records, P.O. Box 68760,

State

Registrar

Medical

29a, Certifier (Check only one)

URAKHIA

Day, Year)

4

29b. Signature and title of certifier

and manner stated

009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D36942